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# TIONAL HEALTH PROGRAM

## HEARINGS

BEFORE A

## SUBCOMMITTEE OF THE
## COMMITTEE ON LABOR AND PUBLIC WELFARE
## UNITED STATES SENATE

EIGHTIETH CONGRESS
FIRST SESSION

ON

## S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

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## S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

## PART 1

MAY 21, 22, 23, 28, 29, JUNE 4, 5, AND 6, 1947

Printed for the use of the Committee on Labor and Public Welfare

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# NATIONAL HEALTH PROGRAM

U.S. Congress. Senate. Committee on Labor and Public Welfare.

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# NATIONAL HEALTH PROGRAM

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## WEDNESDAY, MAY 21, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met pursuant to call at 9:30 a. m., in the committee hearing room, Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Taft, Smith, Donnell, Murray, and Pepper.

(S. 545 is as follows:)

[S. 545, 80th Cong., 1st sess.]

A BILL To coordinate the health functions of the Federal Government in a single agency; to amend the Public Health Service Act for the following purposes: To expand the activities of the Public Health Service; to promote and encourage medical and dental research in the National Institute of Health and through grants-in-aid to the States; to construct in the National Institute of Health a dental research institute; and for other purposes

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That this Act may be cited as the "National Health Act of 1947".

Sec. 2. The Congress hereby finds and declares—

(*a*) That health and medical functions are widely scattered through many agencies in the Federal Government with resultant confusion and duplication of effort, and that because of this diffuse organization State health administrators and other State officials find it necessary to submit plans and budgets to numerous Federal officials responsible for health programs authorized under a large number of unrelated statutes;

(*b*) That there are inadequacies in the distribution of public health services and of medical and dental services in the United States, with the result that some persons are unable to secure adequate health and medical services;

(*c*) That it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status; and

(*d*) That it is the further policy of the United States to make provision for voluntary deductions from the salary of Federal employees of premiums directed by them to be paid to voluntary nonprofit health-insurance funds.

Sec. 3. When used in this Act the terms defined in section 2 of the Public Health Service Act, as amended, shall have the same meaning as in that Act, as amended.

### TITLE I—NATIONAL HEALTH AGENCY

Sec. 101. (*a*) There is hereby created in the executive branch of the Government an independent agency to be known as the National Health Agency, which shall be administered by a National Health Administrator, who shall be appointed by the President, by and with the advice and consent of the Senate, and who shall receive compensation at the rate of $15,000 per annum.

(*b*) The Administrator shall cause an official seal to be made for the Agency of such device as the President shall approve, and judicial notice shall be taken thereof.

(*c*) The Administrator, who shall engage in no other business, vocation, or employment, shall be a citizen of the United States and a doctor of medicine licensed to practice in one or more of the States and who is outstanding in the field of medicine.

SEC. 102. (*a*) It shall be the purpose of the Agency to promote the general welfare of the people of the United States by aiding and fostering progress throughout the Nation in the field of health and medicine and by centralizing in the Agency the activities of the Federal Government relating to health.

(*b*) To carry out the purposes of subsection (*a*) the Agency shall—

(1) encourage the development throughout the Nation of health services and facilities;

(2) advise and cooperate with other agencies and departments of the Federal Government, and with State governments and agencies, and with private agencies functioning in the field of health;

(3) collect and analyze statistics and make studies, investigations, and reports on conditions, problems, and needs in the field of health in the United States and in other countries, and disseminate and make available information in this field;

(4) make reports and recommendations with respect to the most efficient policies and methods for the promotion of health and related services; and

(5) carry out such specific duties as may be entrusted to it by this and subsequent enactment of Congress, and exercise general supervision over the agencies transferred to it pursuant to section 103.

(*c*) The Agency shall have responsibility for Federal governmental activities concerned with—

(1) the administration of funds appropriated as grants to States for medical and hospital care, dental care, hospital facilities, and all other health activities;

(2) the prevention of disease through water purification, sewage treatment, and the elimination of lake and stream pollution, and promotion of research toward this end;

(3) the promotion of maternal, prenatal, and child care, and the study and dissemination of information on child growth, development, and nutrition;

(4) the protection of the national health by promoting purity, standard potency, and truthful and informative labeling of foods, drugs, and cosmetics;

(5) the training and rehabilitation of persons vocationally handicapped because of permanent disability with the objective of placing such persons in remunerative employment; and

(6) the administration of the Hospital Survey and Construction Act of August 13, 1946; and

(7) such related matters as shall aid the States and the people of the United States in the maintenance of adequate and efficient health facilities and otherwise promote the national health.

(*d*) Nothing in this section shall be deemed to grant to the Agency or to any constituent unit thereof any powers, functions, or duties other than those transferred pursuant to subsections 103 (a) and (b).

(*e*) Nothing in this title shall be deemed to transfer to the Agency any powers, functions, or duties exercised by the Army, the Navy, or the Veterans' Administration.

SEC. 103. (*a*) Upon the effective date of this title, as provided in section 108, there are hereby transferred to the Agency the following agencies, and their functions, powers, and duties: The Public Health Service, Saint Elizabeths Hospital, and the Food and Drug Administration.

(*b*) Upon the effective date of this title, as provided in section 108, there are hereby transferred to the Agency the functions and duties of the Children's Bureau in the Social Security Administration concerned with the administration of title V, parts 1 and 2, of the Social Security Act, as amended, and the functions and duties of the Division of Health Studies in the Bureau of Research and Statistics of the Social Security Administration.

(*c*) Upon the transfers provided for in subsections (a) and (b) all laws relating to any agency or function transferred shall, insofar as such laws are not inapplicable, remain in full force and effect. Any transfer of personnel pursuant to this title shall be without change in classification or compensation, except that this requirement shall not operate to prevent the adjustment of classification or compensation to conform to the duties which may be assigned to such transferred personnel. All orders, rules, regulations, permits, or other privileges made, issued, or granted by any agency, or in connection with the functions, so transferred, and in effect at the time of the transfer, shall continue in effect to the same extent as if such transfer had not occurred, until modified, superseded, or repealed. No suit, action, or other proceeding lawfully commenced by or against any agency or any officer of the United States acting in his official capacity shall abate by reason of any transfer made pursuant to this title, but the court, on motion or supplemental petition filed at any time within twelve months after such transfer takes effect, showing necessity for a survival of such suit, action, or other proceeding to obtain a settlement of the questions involved, may allow the same to be maintained by or against the appropriate agency or officer of the United States.

(*d*) All personnel and property (including office equipment and records) of the agencies which are transferred under subsection (a) shall be transferred to the Agency.

(*e*) The personnel primarily concerned with, and the property (including office equipment and records) used in connection with the functions transferred to the Agency under subsection (b) shall be transferred to the Agency.

(*f*) So much of the unexpended balances of the appropriations, allocations, or other funds available or to be made available for the use of the agencies and of officers and employees of the agencies transferred, and of agencies and officers and employees of agencies some or all of whose functions are transferred under this section, as the Director of the Bureau of the Budget with the approval of the President shall determine, shall be transferred to the Agency, but only for the use of such agency or function herein transferred to the Agency for whose use such appropriation, allocation, or other fund was originally provided. In determining the amount to be transferred, the Director of the Bureau of the Budget may include an amount to provide for the liquidation of obligations incurred against such appropriations or other funds prior to the transfer.

(*g*) The Director of the Bureau of the Budget is hereby authorized and directed to make a study of the activities of the several departments and agencies of the Federal Government with a view to determining whether any activities of such departments and agencies relating to health, but not transferred to the Agency in this title, should, in the interests of economy and simplicity of administration, be transferred to the Agency; and to complete such study and report the results thereof to the Congress by December 31, 1947.

SEC. 104. (a) The Agency shall be composed of the following constituent units: (1) The Office of the Administrator; (2) the Public Health Service, which in turn shall assume the administration of Saint Elizabeths Hospital and Freedmen's Hospital; (3) the Office of Medical and Hospital Care Services; (4) the Office of Dental Care Services; (5) the Office of Maternal and Child Health; (6) the Office of Health Statistics; (7) the Food and Drug Administration; and (8) such other constituent units as the Administration finds necessary.

(b) The organization of the Food and Drug Administration shall remain unchanged except as it may conflict with specific provisions of this title. The Surgeon General of the Public Health Service shall be appointed as provided in section 204 of the Public Health Service Act. The heads of the other constituent units of the Agency set forth herein shall be appointed by the Administrator.

(c) The Director of the Office of Medical and Hospital Care Services shall be a doctor of medicine licensed to practice medicine in one or more States, who has had at least five years of active medical practice and who is outstanding in the field of medicine. The Director of the Office of Dental Care Services shall be a doctor of dental surgery who has had at least ten years of active practice and who is outstanding in the field of dentistry.

(d) Within the Office of Maternal and Child Health there shall be an Advisory Council on Maternal and Child Care to be appointed by the Administrator, which shall advise and consult with the head of the Office of Maternal and Child Health in the formulation and administration of the medical and technical activities of said Office. Such council shall be composed of eight members, at least three of whom shall be doctors of medicine who are specialists in obstetrics or pediatrics. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the first terms of the original members shall expire, as designated by the Surgeon General at the time of appointment, two at the end of one year, two at the end of two years, two at the end of three years, and two at the end of four years after the date of appointment. At the time of appointment the Administrator shall designate one member to be chairman of the council.

Each member of the Advisory Council on Maternal and Child Care, while attending meetings of such council or while otherwise serving pursuant to this section, shall be entitled to receive compensation at a rate to be fixed by the Administrator, but not to exceed $25 per diem, and shall also be entitled to receive an allowance for actual and necessary traveling and subsistence expenses while so serving away from his place of residence.

SEC. 105. The Administrator is authorized to make such expeditures (including expenditures for personal services and rent at the seat of government and elsewhere, for lawbooks, books of reference and periodicals, and for printing and binding) as may be necessary to carry out the provisions of this title, and as may be provided for by the Congress from time to time.

SEC. 106. The Administrator shall make at the close of each fiscal year a report in writing to Congress and the President giving an account of all moneys received and disbursed by him and the Agency, describing the work done by the Agency, and making such recommendations as he shall deem necessary for the effective performance of the duties and purposes of the Agency.

SEC. 107. There is authorized to be appropriated for the administrative expenses of the Agency, including such expenses as are described in section 105, for the fiscal year ending June 30, 1948, and each year thereafter, the sum necessary for such purposes.

SEC. 108. The Administrator shall make a study of the organization and staffing of the Agency and, within six months after the effective date of this title, shall report to the Congress his findings and recommendations for promoting the more efficient and effective operation of the Agency. Such study shall cover all aspects of the organization and staffing of the Agency and of its constituent units and shall include (1) salaries, (2) the desirability of retaining or modifying the commissioned corps of the Public Health Service, and (3) the desirability of establishing an Office of Health and Medical Research as a constituent unit of the Agency.

SEC. 109. This title shall take effect July 1, 1947. The Administrator may be appointed by the President, and his appointment confirmed by the Senate, at any time after the enactment of this title, but such appointment shall not become effective until July 1, 1947.

## TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 201. Section 2 (c) of the Public Health Service Act is amended to read as follows:

"(c) The term 'Administrator' means the National Health Administrator."

SEC. 202. Section 2 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(1) The term 'Agency' means the National Health Agency."

SEC. 203. Section 314 of the Public Health Service Act is amended by adding a new subsection following subsection (b) as follows:

"(c) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention and control of cancer, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention and control of such disease, including the provision of appropriate facilities for diagnosis and including the training of personnel for State and local health work, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to cancer, and to administer this section with respect to such disease, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, and for each fiscal year thereafter, the sum of $10,000,000."

Section 314 of the Public Health Service Act is further amended by renumbering subsections (c) through (j) to read (d) through (k), respectively.

SEC. 204. The Public Health Service Act is hereby amended by adding at the end thereof the following new titles:

## "TITLE VII—GENERAL MEDICAL SERVICE FOR FAMILIES AND INDIVIDUALS WITH LOW-INCOME

### "PART A—MEDICAL CARE SURVEY

"SEC. 701. In order to assist the States in carrying out the purposes of section 711, there is hereby authorized to be appropriated the sum of $3,000,000, to remain available until expended. The sums appropriated under this section shall be used for making payments to States which have submitted, and had approved by the Director, State applications for funds for carrying out such purposes.

"Sec. 702. (a) To be approved, a State application for funds for carrying out the purposes of section 701 must—

"(1) designate a single State agency as the sole agency for carrying out such purposes: *Provided*, That after a State plan has been approved under section 712 (b), any further survey or programing functions shall be carried out pursuant to section 712 (a) (9), by the agency designated in accordance with section 712 (a) (1);

"(2) provide for the designation of a State advisory council, which shall include representatives of nongovernment organizations or groups, and of State agencies, concerned with the provision of medical or hospital care services, including representatives of the users of such services selected from among persons familiar with the need for such services in urban or rural areas, to consult with the State agency in carrying out such purposes;

"(3) provide for making an inventory and survey in accordance with section 712 (a) (7) containing all information required by the Director, and for developing a program in accordance with section 712 (a) and with regulations prescribed under section 715 (a); and

"(4) provide that the State agency will make such reports, in such form and containing such information as the Director may from time to time reasonably require and give the Director, upon demand, access to the records on which such reports are based.

"(b) The Director shall approve any application for funds which complies with the provisions of subsection (a).

"Sec. 703. (a) Each State for which a State application under section 702 has been approved shall be entitled to an allotment of such proportion of any appropriation made pursuant to section 701 as its population bears to the population of all the States, and within such allotment it shall be entitled to receive 33⅓ per centum of its expenditures in carrying out the purposes of section 701 in accordance with its application: *Provided*, That no such allotment to any State shall be less than $10,000. The Director shall from time to time estimate the sum to which each State will be entitled under this section, during such ensuing period as he may determine, and shall thereupon certify to the Secretary of the Treasury the amount so estimated, reduced or increased, as the case may be, by any sum by which the Director finds that his estimate for any prior period was greater or less than the amount to which the State was entitled for such period. The Secretary of the Treasury shall thereupon, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Director, the amount so certified.

"(b) Any funds paid to a State under this section and not expended for the purposes for which paid shall be repaid to the Treasury of the United States."

## "Part B—Medical Care Services

"Sec. 711. In order to assist the States to provide general health, hospital, and medical services for families and individuals with low income in accordance with the provisions of this title, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, and for each of the four succeeding years, the sum of $200,000,000. The sums appropriated pursuant to this section shall be used for making payments to the States which have submitted and had approved by the Director State plans in accordance with the provisions of this title. During and after said five years Congress shall review the program and determine the amount to be authorized thereafter.

"Sec. 712. (a) Any State desiring to take advantage of this title may submit a State plan for carrying out its purposes. Such plan must—

"(1) designate a single State agency as the sole agency for the administration of the plan or designate such agency as the sole agency for supervising the administration of the plan, providing that on or before 1949 such agency shall be the State health agency;

"(2) provide for the designation by the Governor of a State medical and hospital care advisory council, which shall include representatives of nongovernment organizations or groups, and of State agencies concerned with the administration or utilization of health, medical, or hospital services, including representatives of State medical associations, State hospital associations, voluntary nonprofit prepaid medical care plans and voluntary nonprofit prepaid hospital plans, or other groups interested in the improvement of medical and hospital services and in the better distribution thereof;

"(3) contain satisfactory evidence that the State agency designated in accordance with paragraph (1), in cooperation with other public and private agencies, will have authority to carry out such plan in conformity with this title;

"(4) set forth a State-wide program designed and calculated to provide within five years—

"(a) hospital services, surgical services, and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such; and

"(b) periodic physical examinations for all children in elementary and secondary schools in the State.

"Such program may, at the option of the State, provide medical care services in one or more of the following ways: In institutions, in the home, or in physicians' offices. Such program may also provide for the furnishing of such services to such families and individuals by means of payments (in the nature of premiums or partial premiums or reimbursement of expenses or otherwise) by the State, to any voluntary health, medical, or hospital insurance fund, or other fund, operated not for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor. Such program shall provide for the collection of proper charges of less than the total cost of such services from persons unable to pay in whole, but able to pay in part therefor. Such program may include and take account of services rendered or to be rendered by governmental subdivisions of the State, and by private organizations operating not for profit, and may provide for the payment to such institutions by the State or subdivision for care to such families and individuals. Such program may also include payments to physicians practicing in areas which, without such payments, would be unable to provide sufficient income to attract a practicing physician.

"(5) describe the financial contribution for the support of the plan to be made by the State, its local subdivisions, and its private institutions, which contributions shall be sufficient to carry out the program described in paragraph (4) at the end of said period of five years. The financial contribution to be made by the State and its governmental subdivisions shall be at least equal to the amount contributed for similar purposes in the year 1946, and at least equal to the Federal aid payable under this title: *Provided*, That nothing herein shall modify obligations assumed by the Federal Government under other statutes for the medical and hospital care of veterans;

"(6) set forth the relative need of the various proposals required to carry out the plan and provide for the proper priority between such proposals, based upon such need, as financial resources become available;

"(7) be based on a State-wide inventory of existing medical, surgical, and hospital care, including that provided by the State and by private organizations, and shall describe in detail the extension of such services to the end that they be furnished without discrimination on account of race, creed, or color to all persons unable to pay in full therefor;

"(8) provide that the State agency will make such reports in such form and containing such information as the Director may from time to time reasonably require and give the Director, upon demand, access to the records upon which the information is based;

"(9) provide that the State agency will from time to time review its State plan and the operation thereof and submit to the Director any modifications thereof which it considers necessary.

"(b) The Director shall approve any plan and any modification thereof which fulfills the conditions specified in subsection (a). If any such plan or modification thereof shall have been disapproved by the Director for failure to comply with subsection (a), the National Health Council shall, upon request of the State agency, afford it an opportunity for hearing. If such Council determines that the plan or modification complies with the provisions of such subsection the Director shall thereupon approve such plan or modification. No plan or modification shall be disapproved because the Director disapproves of the methods proposed if the program is designed and calculated by July 1, 1952, to provide hospital services, surgical services, medical services, and periodic physical examinations as required by section 712 (a) (4) at a cost within the probable financial resources of the State with Federal aid. It is intended that the State shall devise in each case the methods by which this end is attained.

"SEC. 713. Each State for which a State plan has been approved prior to or during a fiscal year shall be entitled for such year to an allotment of a sum bearing the same ratio to the sum appropriated pursuant to section 711 for such year as the product of (a) the population of such State, and (b) its percentage of tax-paying ability, bears to the sum of the corresponding products for all the States having plans approved. Its percentage of tax-paying ability shall be that percentage which bears the same ratio to 50 per centum as the per capita income of the continental United States (excluding Alaska) bears to the per capita income of such State, except that such percentage shall in no case be more than 66⅔ per centum or less than 25 per centum. The Director with the approval of the Administrator shall calculate the allotments to be made under this section and notify the Secretary of the Treasury of the amounts thereof.

"Sums allotted to a State for a fiscal year and remaining unencumbered at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted to such State for such next fiscal year. Any amount of the sum authorized to be appropriated for a fiscal year which is not appropriated for such year, or which is not allotted in such year by reason of the failure of any State or States to have plans approved under this title, or any amount allotted to a State, but remaining unencumbered at the end of the period for which it is available to such State, is hereby authorized to be appropriated for the next fiscal year in addition to the sum otherwise authorized under section 711.

"SEC. 714. (a) At the end of each year each State shall make a complete report to the Director setting forth in full the activities of the State and its governmental subdivisions in the field covered by this title showing the manner in which the funds received from the Federal Government have been expended by the State and its governmental subdivisions in connection therewith together with such other information as the Director may reasonably require. If the Director, after reasonable notice and opportunity for hearing to the State agency, finds (1) that the State agency is not complying substantially with the provisions of the plan theretofore approved by the Director; or (2) that any Federal funds have been diverted from the purposes for which they have been allotted or paid under this title; or (3) that the State and its governmental subdivisions have failed to provide toward the carrying out of such plan at least as much money as they have received from the Federal Government, the Director, with the approval of the Administrator, shall forthwith notify the Secretary of the Treasury and the State agency that no further certification will be made under section 713, and he shall withhold such further certifications until there is no longer any failure to comply.

"(b) If any State is dissatisfied with the Director's action under subsection (a), such State may appeal to the United States circuit court of appeals for the circuit in which such State is located. The summons and notice of appeal may be served at any place in the United States. The Director shall forthwith certify and file in the court the transcript of the proceedings and record on which he based his action.

"The findings of fact by the Director, unless substantially contrary to the weight of evidence, shall be conclusive; but the court for good cause shown may remand the case to the Director to take further evidence, and the Director may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

"The court shall have jurisdiction to affirm the action of the Surgeon General or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in sections 239 and 240 of the judicial code, as amended.

"SEC. 715. (a) The Director is authorized to make such administrative regulations as he finds necessary to carry out the provisions of this title.

"(b) In administering this title, the Director shall consult with a National Medical Care Council consisting of the Director ex officio, who shall serve as Chairman, and eight members appointed by the Administrator. Five of the eight appointed members shall be persons who are outstanding in fields pertaining to medical and hospital care, at least four of whom shall be doctors of medicine. The other three appointive members shall be persons familiar with the needs for medical and hospital care in urban or rural areas. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire as designated by the Administrator at the time of appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year, and two at the end of the fourth year after the date of the appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served two consecutive terms immediately preceding his reappointment. The Council is authorized to appoint such special and technical committees as may be useful in carrying out its functions. Appointed Council members and members of advisory or technical committees while serving on the business of the council, shall receive compensation at rates fixed by the Administrator, but not exceeding $25 per day, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while serving away from their places of residence. The Council shall meet as frequently as the Administrator deems necessary, but not less than once each quarter. Upon request by three or more members, it shall be the duty of the Administrator to call a meeting of the Council.

"(c) In administering the provisions of this title the Director is authorized to utilize the services and facilities of any executive department or agency in accordance with an agreement with the head thereof. Payment for such services and facilities shall be made in advance or by way of reimbursement, as may be agreed upon between the Director and the head of the department or agency furnishing them.

"Sec. 716. Whenever in his opinion the purposes of this title would be promoted by a conference, the Director may invite representatives of as many State agencies, designated in accordance with section 712 (a) (1), to confer as he deems necessary or proper. Upon the application of five or more of such State agencies, it shall be the duty of the Director to call a conference of representatives of all State agencies joining in the request. A conference of the representatives of all such State agencies shall be called annually by the Director.

"Sec. 717. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of the health services with respect to which any funds have been or may be expended under this title.

"Sec. 718. (a) As used in this title, the term 'Council' means the National Health Council.

"(b) As used in this title, the term 'Director' means the Director of Medical and Hospital Care Services.

## "TITLE VIII—DENTAL HEALTH SERVICES FOR SCHOOL CHILDREN AND FAMILIES AND INDIVIDUALS WITH LOW INCOME

### "Part A—Dental Survey

"Sec. 801. In order to assist the States in carrying out the purposes of section 811, there is herey authorized to be appropriated the sum of $1,000,000, to remain available until expended. The sums appropriated under this section shall be used for making payments to States which have submitted, and had approved by the Director, State applications for funds for carrying out such purposes.

"Sec. 802. (a) To be approved, a State application for carrying out the purposes of section 801 must—

"(1) designate a single State agency as the sole agency for carrying out such purposes: *Provided*, That after a State plan has been approved under section 812 (b), any further survey or programming function shall be carried out, pursuant to section 812 (a) (8), by the agency designated in accordance with section 812 (a) (1);

'(2) provide for the designation of a State advisory council, which shall include representatives of nongovernment organizations or groups, and of State agencies, concerned with the provision of dental care services, including representatives of the users of dental care services selected from among persons familiar with the need for such services in urban or rural areas, to consult with the State agency in carrying out such purposes;

"(3) provide for making an inventory and survey in accordance with section 812 (a) (7) containing all information required by the Director, and for developing a program in accordance with section 812 (a) and with regulations prescribed under section 815 (a); and

"(4) provide that the State agency will make such reports, in such form and containing such information, as the Director may from time to time reasonably require, and give the Director, upon demand, access to the records on which such reports are based.

"(b) The Director shall approve any application for funds which complies with the provisions of subsection (a).

"SEC. 803. (a) Each State for which a State application under section 802 has been approved shall be entitled to an allotment of such proportion of any appropriation made pursuant to section 801 as its population bears to the population of all the States, and within such allotment it shall be entitled to receive 33⅓ per centum of its expenditures in carrying out the purposes of section 801 in accordance with its application: *Provided*, That no such allotment to any State shall be less than $10,000. The Director shall from time to time estimate the sum to which each State will be entitled under this section, during such ensuing period as he may determine, and shall thereupon certify to the Secretary of the Treasury the amount so estimated, reduced or increased, as the case may be, by any sum by which the Director finds his estimate for any prior period was greater or less than the amount to which the State was entitled for such period. The Secretary of the Treasury shall thereupon, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Director, the amount so certified.

"(b) Any funds paid to a State under this section and not expended for the purposes for which paid shall be repaid to the Treasury of the United States.

### "PART B—DENTAL CARE SERVICES

"SEC 811. In order to assist the States to provide dental examination for school children, and necessary dental care for those school children and other individuals and families unable to pay the whole cost of such care in accordance with the provisions of this title, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, the sum of $8,000,000; for the fiscal year ending June 30, 1948 the sum of $12,000,000; for the fiscal year ending June 30, 1949, the sum of $16,000,000; and for the fiscal years ending June 30, 1950, and June 30, 1951, the sum of $20,000,000 each. The sums appropriated pursuant to this section shall be used for making payments to States which have submitted, and had approved by the Director, State plans in accordance with the provisions of this title.

"SEC. 812. (a) Any State desiring to take advantage of this title may submit a State plan for carrying out its purposes. Such plan must—

"(1) designate a single State agency as the sole agency for administration of the plan or designate such agency as the sole agency for supervising the administration of the plan, providing that after 1949 such agency shall be the State health agency;

"(2) provide for the designation by the Governor of a State dental health advisory council, which shall include representatives of nongovernmental groups or organizations, and of State agencies, concerned with the providing and administering of dental health services, including representatives of State dental associations and other groups interested in the improvement of dental health and in the better distribution of dental services;

"(3) contain satisfactory evidence that the State agency, designated in accordance with paragraph (1), in cooperation with other public and private agencies, will have authority to carry out such plan in conformity with this title;

"(4) set forth a State-wide program designed and calculated within five years to provide for the periodic inspection of the teeth of all children in the elementary and secondary grades of the public and nonpublic schools in the State, and to provide for the dental care and treatment of dental diseases and dental defects, including prophylaxis, filling, X-ray, extraction, and related care, other than straightening, of the teeth of those children in the elementary and secondary grades of public and nonpublic schools of the State who, and whose family or guardian, have insufficient income to pay for the whole cost of such services. Such program may also at the option of the State provide dental care for those families and individuals in the State having insufficient income to pay the whole cost of such service. Such program shall provide for the collection of proper charges of less than the total cost of services rendered under this paragraph to individuals and families unable to pay in whole, but able to pay in part therefor. Such program may also provide for the furnishing of such services to such families and individuals by means of payments (in the nature of premiums, or partial premiums, or reimbursement of expenses, or otherwise) by the State to any nonprofit voluntary dental care fund or other fund operated not for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor. Such program may include and take account of services rendered or to be rendered by governmental subdivisions of the State, and by private organizations operating not for profit, and may provide for the payment to such institution by the State or subdivision for dental care to such families and individuals. Such program may include payments to dentists practicing in areas which, without such payments, would be unable to provide sufficient income to attract a practicing dentist. Such program may provide for the training of personnel for State and local public health work in dentistry;

"(5) describe the financial contribution for the support of the plan to be made by the State, its local subdivisions, and its private institutions, which contributions shall be sufficient to carry out the program described in paragraph (4) at the end of said period of five years. The financial contribution to be made by the State and its governmental subdivisions shall be at least equal to the Federal aid payable under this title; provided that nothing herein shall modify obligations assumed by the Federal government under other statutes for the medical and hospital care of veterans;

"(6) be based on a State-wide inventory of existing dental care including that provided by the State and by private organizations, and shall describe in detail the extension of such services to the end that they be furnished without discrimination on account of race, creed, or color to all persons unable to pay in full therefor;

"(7) provide that the State agency will make such reports in such form and containing such information as the Director may from time to time reasonably require and give the Director, upon demand, access to the records upon which the information is based;

"(8) provide that the State agency will from time to time review its State plan and the operation thereof and submit to the Director any modifications thereof which it considers necessary.

"(b) The Director shall approve any State plan and any modification thereof which fulfills the conditions specified in subsection (a). If any such plan or modification thereof shall have been disapproved by the Director for failure to comply with subsection (a), the National Dental Health Council shall, upon request of the State agency, afford it an opportunity for hearing. If such Council determines that the plan or modification complies with the provisions of such subsection, the Director shall thereupon approve such plan or modification. No plan or modification shall be disapproved because the Director disapproves of the methods proposed if the program is designed and calculated by July 1, 1952, to provide dental care, treatment, and examination, as required by section 812 (a) (4), at a cost within the probable financial resources of the State with Federal aid. It is intended that the State shall devise in each case the methods by which this end is attained.

"Sec. 813. Each State for which a State plan has been approved prior to or during a fiscal year shall be entitled for such year to an allotment of a sum bearing the same ratio to the sum appropriated pursuant to section 811 for such year as the product of (a) the population of such State, and (b) its percentage of tax-paying ability, bears to the sum of the corresponding products for all of the States having plans approved. Its percentage of tax-paying ability shall be that percentage which bears the same ratio to 50 per centum as the per capita income of the continental United States (excluding Alaska) bears to the per capita income of such State, except that such percentage shall in no case be more than 66⅔ per centum or less than 25 per centum. The Director with the approval of the Administrator shall calculate the allotments to be made under this section and notify the Secretary of the Treasury of the amounts thereof.

"Sums allotted to a State for a fiscal year and remaining unencumbered at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted to such State for such next fiscal year. Any amount of the sum authorized to be appropriated for a fiscal year which is not appropriated for such year, or which is not allotted in such year by reason of the failure of any State or States to have plans approved under this title, in any amount allotted to a State, but remaining unencumbered at the end of the period for which it is available to such State, is hereby authorized to be appropriated for the next fiscal year in addition to the sum otherwise authorized under section 801.

"Sec. 814. (a) At the end of each year each State shall make a complete report to the Director setting forth in full the activities of the State and its governmental subdivisions in the field covered by this title showing the manner in which the funds received from the Federal Government have been expended and the amount expended by the State and its governmental subdivisions in connection therewith together with such other information as the Director may reasonably require. If the Director after reasonable notice and opportunity for hearing to the State agency finds (1) that the State agency is not complying substantially with the provisions of the plan theretofore approved by the Director, or (2) that any Federal funds have been diverted from the purposes for which they have been allotted or paid under this title, or (3) that the State and its governmental subdivisions have failed to provide toward the carrying out of such plan at least as much money as they have received from the Federal Government, the Director, with the approval of the Administrator, shall forthwith notify the Secretary of the Treasury and the State agency that no further certification will be made under section 813, and he shall withhold further certification until there is no longer any failure to comply.

"(b) If any State is dissatisfied with the Director's action under subsection (a), such State may appeal to the United States court of appeals for the circuit in which such State is located. The summons and notice of appeal may be served at any place in the United States. The Director shall forthwith certify and file in the court the transcript of the proceedings and the record on which he based his action.

"The findings of fact by the Director, unless substantially contrary to the weight of evidence, shall be conclusive; but the court for good cause shown may remand the case to the Director to take further evidence, and the Director may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

"The court shall have jurisdiction to affirm the action of the Director or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in sections 239 and 240 of the judicial code, as amended.

"Sec. 815. (a) The Director is authorized to make such administrative regulations as he finds necessary to carry out the provisions of this title.

"(b) In administering this title, the Director shall consult with a National Dental Health Council consisting of the Director ex officio, who shall serve as chairman, and six members appointed by the Administrator. The six appointed members shall be persons not otherwise in the employ of the Federal Government who are outstanding in fields pertaining to dental health, at least four of whom shall be doctors of dental surgery who have had not less than ten years of active practice and who are licensed to practice dentistry in one or more of the States. The other two appointive members shall be persons familiar with the needs for dental care in urban or rural areas. Each appointed member shall hold office for a term of three years except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire, as designated by the Administrator at the time of appointment, two at the end of the first year, two at the end of the second year, and two at the end of the third year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served for two consecutive terms immediately prior to his reappointment. The Council is authorized to appoint such special advisory and technical committees as may be useful in carrying out its functions. Appointed Council members and members of advisory or technical committees, while serving on the business of the Council, shall receive compensation at rates fixed by the Administrator, but not to exceed $25 per day, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while so serving away from their places of residence. The Council shall meet as frequently as the Administrator deems necessary, but not less than once each quarter. Upon request by three or more members, it shall be the duty of the Administrator to call a meeting of the Council.

"(c) In administering the provisions of this title, the Director is authorized to utilize the services and facilities of any executive department or agency in accordance with an agreement with the head thereof. Payment for such services and facilities shall be made in advance or by way of reimbursement, as may be agreed upon between the Surgeon General and the head of the department or agency furnishing them.

"Sec. 816. Whenever in his opinion the purposes of this title would be promoted by a conference the Director may invite representatives of as many State agencies, designated in accordance with section 802 (a), to confer as he deems necessary and proper. Upon the application of five or more of such State agencies, it shall be the duty of the Director to call a conference of representatives of all State agencies joining in the request. A conference of the representatives of all such State agencies shall be called annually by the Director.

"Sec. 817. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel maintenance, or operation of the dental health services with respect to which any funds have been or may be expended under this title.

"Sec. 818 (a) As used in this title, the term 'Council' means the National Dental Health Council.

"(b) As used in this title, the term 'Director' means the Director of Dental Care Services.

## "TITLE IX—FURTHER RESEARCH AND TRAINING

### "Part A—Dental Research

"Sec. 901. The National Institute of Dental Research shall be a division in the National Institute of Health.

"Sec. 902. In carrying out the purposes of section 301 with respect to dental research, the Surgeon General, through the National Institute of Dental Research, and in cooperation with the National Dental Health Council, is authorized in addition to the powers conferred by section 301—

"(a) to conduct, assist, and foster research, investigations, experiments, demonstrations, and studies relating to the cause, treatment, control, and prevention of dental diseases and impairments;

"(b) to promote the coordination of research conducted by the Institute and similar research conducted by other public and private agencies, organizations, and institutions, and to make grants-in-aid to public and private agencies, organizations, and institutions for conducting the kind of research authorized in paragraph (a);

"(c) to provide fellowships in the National Institute of Dental Research and in other public and private institutions assisted under paragraph (b) with such stipends and allowances (including traveling and subsistence expenses) as he may deem necessary for the purpose of obtaining the consultation and advice of persons who are experts in the field of dental diseases from the United States and abroad, and of training persons to carry on research activities.

"Sec. 903. In cooperating with the Surgeon General in carrying out the authority contained in section 902, the National Dental Health Council is authorized, either itself or through advisory councils which it may establish—

"(a) to review research projects or programs submitted to, or initiated by it, relating to the study of the causes, treatment, control, or prevention, of dental diseases and impairments, and certify approval to the Surgeon General, for prosecution, under section 902, of any such projects which it believes show promise of making valuable contributions to human knowledge with respect to the causes, prevention, or methods of treatment of dental diseases;

"(b) to collect information as to studies which are being carried on in the United States or any other country as to the cause, prevention, or methods of treatment of dental diseases, by correspondence or by personal investigation of such studies, and with the approval of the Surgeon General make available such information through the appropriate publications for the benefit of dental agencies and organizations (public or private), dentists, or any other scientists, and for the information of the general public;

"(c) to review applications from any university, hospital, dental clinic, or other institution, whether public or private, for grants-in-aid for research projects relating to dental health, and to certify to the Surgeon General its approval of grants-in-aid in the cases of such projects as show promise of making valuable contributions to human knowledge with respect to such problems;

"(d) to recommend to the Surgeon General for acceptance conditional gifts pursuant to section 501 of this Act; and

"(e) to make recommendations to the Surgeon General with respect to carrying out the provisions of this part.

"Sec. 904. Upon recommendation pursuant to section 903 (d) to the Surgeon General by the National Dental Health Council of acceptance of conditional gifts pursuant to section 501 of this Act; for study, investigation, or research under the provisions of this part, or for the acquisition of grounds or for the erection, equipment, or maintenance of premises, buildings, or equipment of the National Institute of Dental Research, the Surgeon General may recommend to the Administrator acceptance of such conditional gifts in accordance with section 501. Donations of $50,000 or over in aid of research under this part may be acknowledged by the establishment within the National Institute of Dental Research of suitable memorials to the donors.

"Sec. 905. There are hereby authorized to be appropriated, in order to carry out the purposes of this part for research and scholarships in the field of dental health, the following sums for the years and purposes indicated: For the fiscal year ending June 30, 1947, for grants-in-aid for dental research and training not to exceed $75,000, and for research and scholarships within the National Institute of Dental Research not to exceed $175,000; for the fiscal year ending June 30, 1948, for grants-in-aid for dental research and scholarships not to exceed $150,000, and for research and scholarships within the National Institute of Dental Research not to exceed $250,000; and for subsequent fiscal years for grants-in-aid for dental research and scholarships not to exceed $300,000, and for dental research and scholarships within the National Institute of Dental Research not to exceed $300,000.

### "Part B—New Construction for Research

"Sec. 911. There is hereby authorized to be appropriated a sum not to exceed $2,000,000 for the erection and equipment of a suitable and adequate building and other facilities for the use of the National Institute of Dental Research in carrying out the provisions of this title. The Administrator is authorized to acquire, by purchase, condemnation, donation, or otherwise, a suitable and adequate site or sites in or near the District of Columbia for such building and facilities, and to erect thereon, furnish, and equip such building and facilities when funds are made available. The amount authorized to be appropriated in this section shall include the cost of preparation of drawings and specifications, supervision of construction, and other administrative expenses incident to the work."

Sec. 205. Section 1 of the Public Health Service Act, as amended, is hereby further amended to read:

"Section 1. Titles I to IX, inclusive, of this Act may be cited as the 'Public Health Service Act'."

## TITLE III—MISCELLANEOUS

Sec. 301. The Act of July 1, 1944 (58 Stat. 682), as amended, is hereby further amended by changing the number of title VII to title X, and by changing the numbers of sections 701 to 712, inclusive, and references thereto, to sections 1001 to 1012, respectively.

Sec. 302. All functions relating to the administration of the Public Health Service formerly exercised by the Secretary of the Treasury, and transferred to the Federal Security Administrator pursuant to section 205 (b) of Reorganization Plan Numbered I, are hereby transferred to the National Health Administrator.

Sec. 303. Sections 201 (c) and (d) of the Federal Food, Drug, and Cosmetic Act, as amended (21 U. S. C. 301ff), are hereby amended to read as follows:

"(c) The term 'Agency' means the National Health Agency.

"(d) The term 'Administrator' means the National Health Administrator."

Sec. 304. In the following sections of title 24, United States Code, chapter 4, relating to Saint Elizabeths Hospital, there shall be substituted for the words "Federal Security Administrator", wherever they occur, the words "Surgeon General of the Public Health Service": Sections 164, 165, 166, 167, 168, 169, 170, 180, 181, 184, 191a, 196b, and 211.

Sec. 305. Section 179 of title 24, United States Code, is hereby amended to read as follows:

"The Superintendent of Saint Elizabeths Hospital shall make a report through the Surgeon General of the Public Health Service to Congress annually at the beginning of each regular session, which shall show in detail the receipts and expenditures for all purposes connected with the hospital for the fiscal year preceding such session."

Sec. 306. Upon the direction of any officer or employee of the Government of the United States, requesting the Government to deduct from the salary of such employee a fixed sum or percentage to be paid to any voluntary nonprofit health insurance fund, said sum or percentage shall be deducted from the salary of such employee or officer, and shall be paid as directed by him. The term "United States" in this section shall be deemed to include all departments, bureaus, agencies, and other divisions of the Government and also corporations, the stock of which is wholly owned by the said Government. The term "health insurance fund" shall be deemed to include any nonprofit organization undertaking to provide, or to insure against the expense of, hospital, medical, dental, or any other services connected with health.

Sec. 307. The Secretary of the Treasury is authorized and directed, beginning with the fiscal year ending June 30, 1948, to deposit for each year in a special fund in the Treasury of the United States proceeds of taxes, duties, imposts, or excises in an amount equal to the aggregate of the amounts authorized to be appropriated for such year under this Act. Amounts deposited in such fund shall be available for expenditure only pursuant to appropriations made under authority of this Act, and no moneys shall be payable on any of said appropriations except from said fund. Any amounts remaining in the fund after the expiration of the period for which such amounts are available for expenditure shall be covered into the general fund of the Treasury.

Sec. 308. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

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(S. 1320 is as follows:)

[S. 1320, 80th Cong., 1st sess.]

## A BILL To provide a national health insurance and public health program

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That this Act, divided into titles and sections according to the following table of contents, may be cited as the "National Health Insurance and Public Health Act of 1947".

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## TITLE I—DECLARATION OF PURPOSE

### FINDINGS AND DECLARATIONS

SEC. 101. The Congress hereby finds and declares that—

(a) good health is essential to the security and progress of the Nation and the promotion of the general welfare;

(b) ill health is a major cause of human suffering, family break-down, economic loss, destitution, and dependency;

(c) the health of the Nation is a national concern; its preservation demands the fullest cooperation of individuals and governments, local, State, and Federal, in conjunction with voluntary professional and nonprofessional organizations, and calls for utilization of the Nation's resources to provide the needed health facilities and personnel;

(d) there are serious inadequacies in the availability of health services to the people of the United States, impeding the preservation and improvement of the health, vigor, and security of the American people;

(e) the development of adequate health services is essential to maintain and improve the efficiency, security, and well-being of the American people, to promote maximum employment, production, and free competition in private enterprise, and to increase progressively the standard of living, welfare, and happiness of all of the people of the Nation;

(f) it is the policy of the United States to take such steps and to utilize such of its resources as are necessary toward making adequate health services available to all our people regardless of residence, race, creed, color, or economic status;

(g) as a measure of common defense and national security, it is essential to establish a national health program to encourage the development of more adequate local health services and facilities throughout the Nation;

(h) to promote the general welfare of the people of the United States, the Congress hereby establishes a national health program (1) to aid and foster health and medical progress throughout the Nation; (2) to prevent sicknesss, disability, and premature death; (3) to promote personal relationships between physicians and patients; (4) to stimulate scientific advancement, research, and professional education in medical and related fields; (5) to promote the more effective coordination among general practitioners, specialists, nurses, hospitals, and other persons furnishing health services; (6) to enable patients to have more effective free choice in selecting their physicians; (7) to provide adequate health services consistent with the highest standards of quality; and (8) to be administered locally in accordance with American ideals of democracy and individual freedom and in conjunction with other preventive, diagnostic, and curative services, public and private, in a manner designed to preserve the customary freedom and responsibility of professional persons in the exercise of professional judgment as to the care of a patient.

## TITLE II—PREPAID PERSONAL HEALTH SERVICE BENEFITS

### Part A—Benefits and Eligibility

### CLASSES OF PERSONAL HEALTH SERVICES

Sec. 201. (a) The personal health services to be made available as benefits to eligible individuals as provided in this part are medical services, dental services, home-nursing services, hospital services, and auxiliary services. Each class of services shall be provided by persons (including individuals, partnerships, corporations, associations, consumer cooperatives, and other organizations) who are authorized by applicable State law, and who are qualified under part B of this title, to do so.

(b) Medical services consist of (1) general medical services such as can be rendered by a physician engaged in the general or family practice of medicine, including preventive, diagnostic, and therapeutic care and periodic medical examinations; and (2) specialist services rendered by a physician who is a specialist in the class of services rendered, as defined in section 211 of this Act. Such services may be rendered at the office, home, hospital, or elsewhere, as necessary.

(c) Dental services consist of (1) general dental services rendered by a dentist engaged in the general practice of dentistry, including preventive, diagnostic, and therapeutic care, and periodic dental examinations; and (2) specialist services rendered by a dentist who is a specialist in the class of services rendered, as defined in section 211 of this Act. Such services may be rendered at the office, home, hospital, or elsewhere, as necessary.

(d) Home-nursing services consist of nursing care of the sick rendered in the home by a registered professional nurse or a qualified practical nurse.

(e) Hospital services consist of hospitalization, including necessary nursing services, and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Board (hereinafter referred to as the "Board"), after consultation with the National

Advisory Medical Policy Council (hereinafter referred to as the "Advisory Council"), by regulation designates as essential to good hospital care, for a maximum of sixty days in any benefit year; but hospital services shall not include hospitalization in a mental or nervous disease or tuberculosis hospital or institution, or hospitalization for any day more than thirty days following the diagnosis of tuberculosis or a psychosis. Whenever the Board, after consultation with the Advisory Council, finds that moneys in the account (established by section 271) are adequate and that facilities are available, it may by regulation increase the maximum days of hospitalization in any benefit year.

(f) Auxiliary services consist of such chemical, bacteriological, pathological, diagnostic X-ray and related laboratory services; X-ray, radium, and related therapy; physiotherapy; services of optometrists and chiropodists; and prescribed drugs which are unusually expensive, special appliances, and eyeglasses; as the Board, after consultation with the Advisory Council, by regulation designates as auxiliary services on the basis of its finding that their provision under this title is practicable and is essential to good health care.

### AVAILABILITY OF BENEFITS

SEC. 202. (a) Medical services, hospital services, and, except as otherwise provided in subsection (b) of this section, all other personal health services specified in section 201 shall be made available as benefits to eligible individuals in all health-service areas within the United States as rapidly and as completely as possible having regard for the availability of the professional and technical personnel and the hospital and other facilities needed to provide such services. To this end the resources and needs of each State shall be surveyed and a program developed in each State to assure the maximum participation and use of health personnel and facilities in the provision of benefits, and to encourage improvement in the number and distribution of such personnel and facilities throughout the State. Additional surveys shall be undertaken as required, and the program in the State from time to time modified on the basis thereof.

(b) If the Board, after consultation with the Advisory Council, finds that the personnel or facilities or funds that are or can be made available are inadequate to insure the provision of all services included as dental, home-nursing, or auxiliary services under section 201 of this title, it may by regulation limit for a specified period the services which may be provided as benefits, or modify the extent to which, or the circumstances under which, they will be provided to eligible individuals. Any such restriction or limitation shall be reduced or withdrawn as rapidly as may be practicable; and, in the case of dental services, priority in the reduction or withdrawal of any such restriction or limitation shall be given to children.

(c) The Board shall have the duty of studying and making recommendations as to needed services and facilities for the care of the chronic sick afflicted with physical ailments and for the care of individuals afflicted with mental or nervous diseases, and as to needed provisions for the prevention of chronic physical diseases and of mental or nervous diseases; and of making reports from time to time, with recommendations as to legislation, but the first such report shall be made not later than two years after benefits under this title first become available.

### HOW BENEFITS OBTAINED; FREE CHOICE BY PATIENT

SEC. 203. Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection: *Provided*, That the practitioner, medical group, hospital, or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual. General medical and general dental services may be obtained by request made by the individual directly to the practitioner of the individual's choice. Specialist, home nursing, hospital, and auxiliary services shall be obtained from the specialist, nurse, hospital, or other person of the individual's choice, whenever the practitioner from whom he is receiving medical or dental services as benefits under this title refers him for specialist, home-nursing, hospital, or auxiliary services upon determining that such services are required in the proper care of his particular case; or whenever, upon request of the individual, an administrative medical officer, upon a like determination, refers him for such services. The Board, by regulation, shall dispense with the necessity of referral in cases of emergency, and may dispense with the necessity of referral under specified circumstances or as respects specified classes of services, or both, if it finds, after consultation with the Advisory Council, that such action will be conducive to the provision of more adequate amount and quality of health care and will not unreasonably increase the expenditures from the account for such services.

### ELIGIBILITY FOR BENEFITS

Sec. 204. (a) Every individual shall be eligible for benefits under this title throughout any benefit year if—

(1) he has received (or, in the case of income from self-employment, has accrued)—

(A) not less than $150 in wages during the first four of the last six calendar quarters preceding the beginning of the benefit year; or

(B) not less than $50 in wages in each of six calendar quarters during the first twelve of the last fourteen calendar quarters preceding the beginning of the benefit year (not counting as one of such fourteen calendar quarters any quarter in any part of which the individual was under a total disability which continued for six months or more);

(2) he is entitled, for the first month in the benefit year, to a benefit under title II of the Social Security Act, as amended, or to an annuity under the Civil Service Retirement Act, as amended (5 U. S. C., ch. 14); or

(3) he is on the first day of the benefit year a dependent of an individual who is eligible under paragraph (1) or paragraph (2).

(b) Every individual, not eligible therefor under subsection (a), shall be eligible for benefits under this title during the remainder of a benefit year, beginning with—

(1) the first day of any calendar quarter in such benefit year, if he has received (or, in the case of income from self-employment, has accrued) not less than $150 in wages during the first four of the last six calendar quarters preceding the beginning of such calendar quarter;

(2) the first day of the first month in such benefit year for which he is entitled to a benefit or annuity referred to in subsection (a) (2); or

(3) the first day in such benefit year on which he is or becomes a dependent of an individual who is eligible for benefits under subsection (a) (1) or (2) or under paragraph (1) or (2) of this subsection.

(c) No individual shall be deemed eligible for any personal health services as a benefit under this title which are required by reason of any injury, disease, or disability on account of which any medical, dental, home-nursing, hospital, or auxiliary service is being received, or upon application therefor would be received, under a workmen's compensation law of the United States or of any State, unless equitable reimbursements to the account for the provision of such services as benefits have been made or assured under section 205 of this title. In any case in which an individual receives any personal health service as a benefit under this title with respect to any such injury, disease, or disability, for which no reimbursement to the account has been made or assured, the United States shall to the extent permitted by State law be subrogated to all rights of such individual, or of the person who furnished such service, to be paid or reimbursed, pursuant to such workmen's compensation law, for the cost of furnishing such service.

### PROVISION OF BENEFITS FOR NONINSURED NEEDY AND OTHER INDIVIDUALS

Sec. 205. (a) Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals (including the needy) not otherwise eligible therefor, for any period for which equitable reimbursements to the account on behalf of such needy or other individuals have been made, or for which reasonable assurance of such reimbursements has been given, by public agencies of the United States, the several States, or any of them or of their political subdivisions, such reimbursements to be in accordance with agreements and working arrangements negotiated with such public agencies. Services furnished to such needy or other individuals as benefits shall be of the same quality, be furnished by the same methods, and be paid for through the same arrangements, as services furnished to individuals eligible for benefits under this title.

(b) Federal grants to States under titles I, IV, and X of the Social Security Act, as amended, shall be available to the States for provision of personal-health services for noninsured needy individuals in accordance with the provisions of subsection (a) of this section and of section 282.

## PART B—PARTICIPATION OF PHYSICIANS, DENTISTS, NURSES, HOSPITALS, AND OTHERS

### PHYSICIANS AND DENTISTS; SPECIALISTS

SEC. 211. Any individual who is a physician or a dentist legally authorized in a State to render any services included as general medical services or general dental services shall be deemed qualified to render such services in that State as benefits under this title. Any such individual who is found to possess skill and experience of a degree and kind sufficient to meet standards established for a class of specialist services shall be deemed qualified to receive compensation for specialist services of such class as benefits under this title. The Board, after consultation with the Advisory Council, shall establish standards as to the special skills and experience required to qualify an individual to render each such class of specialist services as benefits under this title, and to receive compensation for such specialist services. In establishing such standards and in determining whether individuals qualify thereunder, standards and certifications developed by professional agencies shall be utilized as far as is consistent with the purposes of this title, and regard shall be had for the varying needs and the available resources in professional personnel of the States and of local health-service areas.

### NURSES

SEC. 212. Any individual shall be deemed qualified to render home-nursing services in a State as benefits under this title if such individual is (a) a professional nurse registered in such State, or (b) a practical nurse (1) who is qualified as such under State standards or requirements, or, in the absence of State standards or requirements, is found to be qualified under standards established by the Board after consultation with the Advisory Council and with nursing agencies, and (2) who furnishes nursing care under the direction or supervision of the State health agency, the health agency of a political subdivision of the State, or an organization supplying and supervising the services of registered professional nurses in the State.

### HOSPITALS

SEC. 213. Any hospital or other institution shall be deemed qualified to furnish all or particular classes of hospital services as benefits under this title if it is qualified to furnish such services under State standards or requirements for the maintenance and operation of hopitals which apply to the class or classes of services to be furnished, or if, in the absence of such State standards or requirements, it is found to afford professional services, personnel, and equipment adequate to promote the health and safety of individuals requiring the class or classes of hospital services to be furnished, according to standards which the Board shall establish after consultation with the Advisory Council.

### AUXILIARY SERVICES

SEC. 214. Any person (as defined in section 281 (1)) who is qualified under State standards or requirements to furnish a class of services included as auxiliary services, or, in the absence of State standards or requirements, is found to be qualified to furnish a class of such services under standards established for such class by the Board after consultation with the Advisory Council, shall be deemed qualified to furnish such class of auxiliary services in that State as benefits under this title.

### AGREEMENTS WITH INDIVIDUAL PRACTITIONERS, HOSPITALS, AND OTHERS

SEC. 215. Any individual (or, in the case of hospital or auxiliary services, any person) qualified under this part to furnish any class or classes of personal health services as benefits may enter into an agreement with the State agency which in accordance with part D has assumed responsibility for the administration in the State of benefits under this title (hereinafter in this title referred to as the "State agency"), to furnish such class or classes of services as benefits to individuals eligible therefor under this title.

### AGREEMENTS WITH VOLUNTARY HEALTH INSURANCE AND OTHER ORGANIZATIONS

SEC. 216. (a) In the provision of personal health services, it shall be the policy to utilize individuals or organizations qualified under this part to render such services, including (1) any organized group of individuals, (2) any partnership, association, or consumer cooperative, (3) any hospital or any hospital and its staff, or (4) any organization operating a voluntary health-service insurance plan or other voluntary health-service plan.

(b) The State agency is authorized to enter into an agreement with any organization referred to in subsection (a) for the provision of personal health services under this title. Any such organization, whether or not it enters into an agreement with the State agency on its own behalf, shall be permitted to act as agent for individuals or other persons in negotiating or in carrying out agreements with the State agency for rendering personal health services under this title.

(c) Any agreement under this section shall provide that each class of personal health services will be furnished only by individuals (or, in the case of hospital or auxiliary benefits, by persons, as defined in section 281 (1)), who are qualified under this part to render such class of services, and each of whom has agreed or has authorized an agreement to be made on his behalf with the State agency that he will furnish such services in accordance with this title and with regulations prescribed thereunder. Each such individual or person shall be responsible, both to the State agency and (in accordance with applicable State law) to individuals eligible for personal health services as benefits, for carrying out such agreement made by him or on his behalf.

### PROVISIONS COMMON TO ALL AGREEMENTS

SEC. 217. (a) Each agreement made under this part shall specify the class or classes of services to be furnished or provided pursuant to its terms, shall contain an undertaking to comply with this title and with regulations prescribed thereunder, shall be made upon terms and conditions consistent with the efficient and economical administration of this title, and shall continue in force for such period and be terminable upon such notice as may be agreed upon.

(b) No agreement under section 216, and no designation of an agent, shall for more than one year preclude any individual or person qualified to furnish personal health services from exercising such rights as he would otherwise have under this part (1) to negotiate and enter into an agreement directly with the State agency, or (2) to designate another agent for such negotiation, or (3) to participate in another agreement under section 216.

(c) No agreement made under this part shall confer upon any individual or other person, or any group or other organization, the right of furnishing or providing personal health services as benefits, to the exclusion in whole or in part of other individuals, persons, groups, or organizations qualified to furnish or provide such services.

(d) If the State agency after investigation finds that an individual or other person under agreement to furnish or provide personal health services as benefits is no longer qualified to furnish or provide such services, or has committed a substantial breach of the agreement, it shall notify such person of its findings, together with the reasons therefor, and in the absence of a request for a hearing by such person under part F, or in the event of a final decision sustaining its findings after any hearing and further review provided under part F, may terminate the agreement and withdraw the person's name from the lists published pursuant to part C. After an agreement has been so terminated, no new agreement shall be entered into with such person under this title unless and until such person gives reasonable assurances to the State agency of his or its ability and willingness to discharge all obligations and responsibilities under a new agreement satisfactorily in accordance with its provisions.

### METHODS OF PAYMENTS FOR SERVICES

SEC. 218. (a) Agreements for the furnishing of medical or dental services (other than specialist services) as benefits under this title shall provide for payment—

(1) on the basis of fees for services rendered as benefits, according to a fee schedule;

(2) on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list;

(3) on a salary basis, whole time or part time; or

(4) on such combinations or modifications of these bases, including separate provision for travel and related expenses, as may be approved by the State agency;

according to each health-service area as the majority of the medical practitioners or of the dental practitioners, respectively, under agreement to furnish such services shall elect: *Provided,* That provision shall be made for another method or methods of payment (from among the methods listed in this subsection) to those medical practitioners or to those dental practitioners who do not elect the method of such majority, when it is found that such alternative method of making payments contributes to carrying out the provisions of section 235 of this title or otherwise promotes the efficient and economical provision of medical or dental services in the area.

(b) Agreements for the furnishing of specialist services as benefits under this title may provide for payments on the basis of fee for service, per case, per session, per capita, on salary (whole time or part time), or other basis, or combination thereof.

(c) Any of the methods of making payments from among the methods listed in subsection (a) or subsection (b) may be used in making payments to groups of practitioners or organizations or other agencies which undertake to provide specialist services as well as general medical or general dental services.

(d) Agreements for the furnishing of hospital services as benefits under this title shall provide for payment on the basis of the reasonable costs of hospitalization furnished as benefits: *Provided,* That the Board, after consultation with the Advisory Council and with representatives of interested hospital organizations, may by regulation prescribe maximum rates for hospitalization furnished as benefits under this title, and such maximum rates may be varied according to classes of localities or types of service. Payments to hospitals shall be based on the least expensive multiple-bed accommodations available in the hospital unless the patient's condition makes the use of private accommodations essential for his proper medical care. An agreement made for furnishing such services shall not affect the right of the hospital or other person with whom the agreement is made to require payments from patients with respect to the additional cost of more expensive facilities occupied at the request of the patient, or with respect to services not included as benefits under this title.

(e) Agreements for the furnishing of home-nursing services or auxiliary services as benefits under this title shall provide for payment in accordance with such methods as the State agency may approve from among those set forth in regulations prescribed pursuant to this title.

(f) In any health-service area where agreements for the furnishing of general medical or general dental services provide for payment only on a per capita basis, the per capita payments with respect to those individuals residing in the area who have failed to select a practitioner or other person to furnish such services to them, or who having made one or more successive selections have been refused by the practitioners or other persons selected, shall be made on a pro rata basis among the practitioners and other persons under agreement to furnish such services in the area.

### AMOUNT OF PAYMENTS FOR SERVICES

SEC. 219. (a) Rates or amounts of payment for particular services or classes of services furnished as benefits under this title shall be adapted to take account of relevant regional, State, or local conditions and practices. In arriving at the payments to be made for services of general medical and dental practitioners, specialists, professional and practical nurses, or other practitioners, regard shall be had for the annual income or its equivalent which the payments will provide, and consideration shall be given to degree of specialization, and to the skill, experience, and responsibility involved in rendering the services. Such payments, together with the other terms and conditions of the agreements made under this part, shall be adequate to provide professional and financial incentives to practitioners to advance in their professions and to practice in localities where their services are most needed, to encourage high standards in the quality of services furnished, to give assistance in their use of opportunities for postgraduate study, and to allow for adequate vacation.

(b) The rates and amounts of payments fixed under the different methods of payments specified in subsections (a), (b), (c), and (e) of section 218, and the methods of making payments, shall assure reasonably equivalent awards for practitioners selecting different methods of payment, in consideration of the value of the services they render.

(c) In order to maintain high standards in the quality of medical or dental services furnished as benefits, a State agency may fix maximum limits for the State or for classes of health-service areas, upon the number of eligible individuals with respect to whom any person may undertake to furnish such services as benefits. The State agency may reduce such limits for a health-service area on the basis of the recommendations of the persons furnishing such services in the area. Any such limits shall take account of professional needs and practices, shall provide suitable exceptions for emergency and temporary situations, and shall not exceed maximum limits fixed by regulations made by the Board, after consultation with the Advisory Council, which regulations may provide for nationally uniform limits or for limits varied to take account of relevant factors.

(d) The making of an agreement under section 216 with a group or other organization shall not operate to increase the payments to be made pursuant to any such agreement over the amounts which, in the absence of such group or organization, would be payable for the same services pursuant to agreements made under section 215 directly with the person or persons who furnish the services.

### PROFESSIONAL RIGHTS AND RESPONSIBILITIES

Sec. 220. (a) Any person who enters into an agreement under this part may terminate such agreement after reasonable notice and after suitable arrangements are made to fulfill professional obligations to eligible individuals.

(b) Every physician, dentist, or nurse agreeing to render services as benefits under this title shall be free to practice his profession in the locality of his own choosing, consistent with the requirements of the laws of the States.

(c) Every physician, dentist, nurse, hospital, or other person entering into an agreement under this part shall be free to the extent consistent with applicable State law and customary professional ethics to accept or reject as a patient any individual requesting his services.

(d) No supervision or control over the details of administration or operation, or over the selection, tenure, or compensation of personnel, shall be exercised under the authority of this title over any hospital which has agreed to furnish personal health services as benefits.

## Part C—Local Administration

### DECENTRALIZATION OF ADMINISTRATION

Sec. 231. In order that personal health-service benefits may be made available promptly and in a manner best adapted to local practices, conditions, and needs, responsibility for administration of the benefits provided under this title in the several local health-service areas shall be decentralized as fully as practicable to local administrative committees or local administrative officers, acting with the advice and assistance, as provided in this part, of local professional committees and, in the case of local administrative officers, the advice and assistance of local area committees. The health-service areas of a State shall be those so designated in the State plan of operations.

### LOCAL ADMINISTRATIVE COMMITTEE OR OFFICER

Sec. 232. The local administrative agency for each local health-service area may, as determined by the State, be either—

(1) a local administrative committee established in accordance with section 233, which shall act through a local executive officer; or

(2) a local administrative officer, who shall act with the advice and assistance of a local advisory committee established in accordance with section 233.

The local administrative committee or officer, with the advice and assistance of such local professional committees as may from time to time be established, shall arrange for the furnishing of personal health-service benefits to eligible individuals in the area and to that end shall—

(a) publish, and make readily available to eligible individuals in the area, lists of the names of all persons who have agreed to furnish personal health services in the area, together with the class or classes of services which each has undertaken to furnish;

(b) disseminate pertinent information concerning the rights and privileges under this title of eligible individuals and of persons qualified to furnish personal health services as benefits;

(c) maintain effective relationships with physicians, dentists, nurses, hospitals, and other persons who have entered into agreements to furnish personal health services in the area, in order to facilitate the furnishing of such services in accordance with such agreements, to assure full and prompt payment to such persons for services so furnished, and to enlist their full cooperation in the administration of benefits under this title in the area;

(d) receive and, to the extent possible in the local area, adjust any complaints which may be made concerning the administration of benefits under this title in the area;

(e) perform such other duties (including the making of payments to persons furnishing personal health services in the area) as may be assigned by the State agency; and

(f) take or initiate such other administrative action as he finds will best carry out, within the area, the provisions of this title, and best effectuate its purposes.

### LOCAL AREA COMMITTEES

SEC. 233. (a) A local area committee shall be established in each health-service area. If designated by the State as a local administrative committee, the local area committee shall perform the functions specified in section 232 and shall formulate policies for the administration of benefits under this title in the area. If designated as an advisory committee, it shall advise and assist in the performance of such functions and the formulation of such policies. The committee, whether administrative or advisory, shall participate in the solution of problems affecting the administration of such benefits, shall promote impartiality and freedom from political influence in such administration, and shall perform related functions to the end that administration in the area may be responsive to the wishes and needs of persons furnishing and receiving benefits in the area, be adapted to local practices and resources, and provide adequate and high quality personal health services to all eligible individuals.

(b) Each local area committee shall consist of not less than eight nor more than sixteen members. The members shall be so selected that a majority of the committee shall be representative of the interests of individuals in the area who are eligible for benefits, and the remaining members shall be chosen from the several professions, hospitals, and other organizations in the area by whom such benefits will be provided.

(c) The local area committee shall meet as often as may be necessary, and whenever one-third or more of the members request a meeting; in the case of a local administrative committee, not less frequently than once each month, and in the case of a local advisory committee, not less frequently than once in each quarter of the year. At least one meeting of the committee each year shall be open to the public, notice of which shall be published and at which any person in the area may participate. At least once each year there shall be a State-wide meeting of local administrative officers and representatives of local administrative committees. At least once in each year there shall be a State-wide meeting of representatives of all local advisory committees in the State, and any reports or recommendations made at such meeting shall on the request of such meeting be transmitted through the State agency to the Board.

### LOCAL PROFESSIONAL COMMITTEES

SEC. 234. Local committees representative of the persons furnishing personal health services in the area shall be established in each health-service area to assist the local administrative committee and its executive officer, or the local administrative officer and the local advisory committee, as the case may be, in the preservation of the customary freedom and responsibility (under applicable State law) of practitioners in the exercise of professional judgment as to the care of patients, and in the solution of technical problems concerning the participation of professional personnel, hospitals, and other qualified persons in the provision of personal health services as benefits, and to advise the local administrative or executive officer and the local area committee regarding matters of professional practice or conduct arising in connection with performance of agreements for the provision of such services. Such local committees shall meet on call of the local administrative committee or officer, as the case may be, or upon their own motion. The members of any such local professional committee may be professional members of the local area committee or other professional persons or both.

### METHODS OF ADMINISTRATION

Sec. 235. (a) In each health-service area the methods of administration shall be such as to—

(1) insure the prompt and efficient care of individuals entitled to personal health services as benefits;

(2) promote personal relationships between physician and patients;

(3) promote coordination among and between general practitioners, specialists, those who furnish auxiliary services, nurses, and hospitals, in the furnishing of services under this title, between them and public-health centers and agencies, and educational, service, research, and other related agencies or institutions, and between preventive, diagnostic, and curative services, public and private;

(4) aid in the prevention of disease, disability, and premature death;

(5) encourage improvement in the number and distribution of professional personnel and facilities; and

(6) insure the provision of adequate service with the greatest economy consistent with high standards of quality.

(b) Local administrative officers shall be appointed by the State agency or the head thereof, in accordance with the merit system provided for in the State plan of operations; local administrative committees shall be appointed by such agency or the head thereof, from individuals residing in the respective health-service areas, and the executive officers of such committees shall be appointed by the committees in accordance with the merit system; the local health-service areas shall be those so designated in such plan; and members of local advisory committees and of local professional committees shall be selected in accordance with methods set forth in such plan.

(c) In exercising their functions and discharging their responsibilities under this title local administrative officers and committees, local advisory committees, and local professional committees shall observe the provisions of this title, and of regulations prescribed thereunder, and of any regulations, standards, and procedures prescribed by the State agency.

## Part D—State Administration

### DECLARATION OF POLICY

Sec. 241. It is the intent of Congress that the benefits provided under this title be administered wherever possible by the several States, in accordance with plans of operations submitted and approved as provided in this part, and in each State insofar as feasible by the same State agency which administers, or supervises the administration of, the State's general public health and maternal and child health programs.

### STATE PLAN OF OPERATIONS

Sec. 242. (a) Any State desiring to assume responsibility for the administration in the State of the personal health-service benefits provided under this title to all individuals in the State who are eligible for such benefits, may do so for the period beginning July 1, 1949 (when benefits first become available under this title), or for the period beginning July 1 of any succeeding year, if it has undertaken, through its legislature, to administer such benefits in accordance with the provisions of this title and with the provisions of regulations and standards prescribed thereunder, and, at least twelve manths in advance, has submitted and had approved a State plan of operations which—

(1) designates as the sole agency for the State-wide administration of benefits under this title a single State agency duly authorized under the law of the State to administer such benefits within the State in accordance with the provisions of this title, the provisions of regulations and standards prescribed thereunder, and the provisions of the State plan;

(2) provides for the designation of a State advisory committee which shall include members who are familiar with the needs for personal health services in urban and rural areas, and who are representative of the interests of

individuals in the State who are eligible for benefits, such members to constitute a majority, and members chosen from the several professions, hospitals, and other organizations in the State by whom such benefits will be provided, to advise the State agency in carrying out the administration of such benefits in the State;

(3) provides for the decentralized administration of this title in the State in accordance with part C, for the designation of local health-service areas, and for such methods of selecting the members of local advisory committees and of local professional committees as are calculated to insure representation of the nature set forth in sections 233 and 234, respectively;

(4) provides such methods of administration, including methods relating to the establishment and maintenance of personnel standards or a merit basis (except that the Board shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Board to be necessary for the proper and efficient administration of such benefits in the State;

(5) provides for the making of surveys of the resources and needs of the State, in accordance with section 202 (a), and sets forth a program for the administration of such benefits in the State which gives reasonable assurance (A) that maximum use will be made of all available health personnel and facilities desiring to participate in the provision of benefits to eligible individuals, (B) that funds alloted to the State for the several classes of benefits will be allocated in such manner as to give reasonable assurance of the availability of services in all health-service areas in the State, and (C) that any maldistribution or other inadequacies in the health personnel or facilities available for such purpose, or in the quality of the services rendered, will be progressively improved as rapidly as may be practicable;

(6) provides that the State agency will make such reports in such form and containing such information as the Board may from time to time reasonably require, and give the Board, upon demand, access to the records upon which such information is based;

(7) provides that all Federal funds paid to the State agency for purposes of carrying out this title in the State shall be properly safeguarded and expended solely for the purposes for which paid, and provides for the repayment by the State to the United States of any such funds lost by the State agency or diverted from the purposes for which paid;

(8) provides for cooperation, including where necessary entering into working agreements (with any appropriate transfer of funds) with other public agencies of the State or of its political subdivisions concerned with programs related to the purposes of this title, and with appropriate agencies of other States or of the United States administering this title, or benefits under this title, in other States.

(b) The Board shall approve any State plan and any modification thereof submitted by the State which it finds complies with the provisions of subsection (a). No change in a State plan shall be required within one year after initial approval thereof, or within one year after any change thereafter required therein, by reason of any change in the regulations or standards prescribed pursuant to this title, except with the consent of the State or in accordance with further action by Congress.

(c) In the event of its disapproval of any plan or any modification therein submitted by a State pursuant to this part, the Board shall notify the State of such disapproval and shall, upon request of the State, afford it reasonable notice and opportunity for a hearing on such disapproval.

(d) If a State has not prior to July 1, 1948, submitted and had approved a plan of operations, the Board shall notify the Governor of the State that the Board will be required to administer this title in the State, commencing July 1, 1949. The Board shall provide for the publication of such notice in at least two newspapers of general circulation in the State. If within sixty days after such notification to the Governor the State has not submitted an approvable plan, the Board shall undertake the administration of this title in the State, commencing July 1, 1949, and shall continue such administration until one year after the submission and approval of a plan of operations in accordance with this section: *Provided*, That the Board may waive the requirement that a State plan must be submitted and approved one year prior to commencement of State administration if it is satisfied in a particular case that the substitution of a shorter preparatory period will not prejudice the interests of eligible individuals in the State.

(e) Whenever the Board, after reasonable notice and opportunity for hearing to the State, finds that the State, having submitted and had approved a plan of operations under this part—

(1) is not complying substantially with the provisions of such plan, or with the provisions of this title or any regulations or standards prescribed thereunder, or

(2) has withdrawn its plan or failed to change it when and as required by a change in this title or in regulations prescribed thereunder,

the Board shall notify the Governor of the State of such findings, together with its reasons therefor and a statement concerning the effect of such findings under this title, and shall provide for the publication of such notice in at least two newspapers of general circulation in this State. If within sixty days following such a notice the State has not taken appropriate action to bring its plan or its administration thereof into conformity with this title and regulations and standards thereunder, the Board shall immediately assume responsibility for the administration of this title in the State and shall administer the same in such State for so long thereafter as the State fails to give reasonable assurances of substantial compliance or fails to submit an approvable plan, as the case may be.

(f) If any State in which the Board has assumed responsibility for the administration of benefits under this title as provided in subsections (d) and (e) of this section, the Board shall have and discharge all authority and duties, in accordance with the provisions of this title, which it finds necessary for that purpose, and the term "State agency" wherever used in part B or part C of this title shall be deemed to refer to the Board.

(g) Nothing in this title shall preclude any State or any political subdivision thereof, whether or not the State has assumed responsibility for the administration of benefits under this title, from furnishing, with funds available from sources other than the account, any additional health services to individuals who are eligible for benefits under this title or any or all health services to individuals who are not so eligible.

## PART E—NATIONAL HEALTH INSURANCE BOARD; NATIONAL ADVISORY MEDICAL POLICY COUNCIL; GENERAL ADMINISTRATIVE PROVISIONS

### NATIONAL HEALTH INSURANCE BOARD

SEC. 251. (a) There is hereby established in the Federal Security Agency a National Health Insurance Board (referred to in this title as the "Board"), to be composed of five members, three of whom shall be appointed by the President by and with the advice and consent of the Senate, and the other two whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security. During his term of membership on the Board, no appointed member shall engage in any other business, vocation, or employment. At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States. Each appointed member shall receive a salary at the rate of $12,000 a year and shall hold office for a term of six years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and (2) the terms of office of the members first taking office after the date of the enactment of this Act shall expire, as designated by the President at the time of appoinment, one at the end of two years, one at the end of four years, and one at the end of six years, after the date of enactment of this Act. The President shall designate one of the appointed members as the Chairman of the Board.

(b) All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator. The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary. The Board may delegate to any of its members, officers, or employees, or with the approval of the Administrator to any other officer or employee of the Federal Security Agency, such of its powers or duties, except that of making regulations, as it may consider necessary and proper to carry out the provisions of this title. The Board may also enter into agreements for the furnishing or provision of personal health services under this title without regard to civil service or other laws pertaining to the appointment, status, or compensation of Federal employees, or pertaining to contracts for personal services, and without regard to section 3709 of the Revised Statutes, as amended, and any person rendering services pursuant to an agreement so made shall not by reason thereof be deemed to be an employee of the United States.

(c) In administering the provisions of this title, the Board is authorized to utilize the services and facilities of any executive department or other agency of the United States in accordance with an agreement with the head thereof. Payment for such services and facilities shall be made in advance or by way of reimbursement, as may be agreed upon with the head of the executive department or other agency furnishing them.

(d) Personnel of the Board shall be appointed by the Administrator upon recommendation of the Board. The Administrator is authorized to detail to the Board, upon its request, any officer or employee of the Federal Security Agency, and in his discretion to reimburse, from funds available for the administration of this title, the appropriation from which the salary or, in the case of commissioned officers of the Public Health Service, the pay and allowances of such officer or employee are paid.

(e) Upon the request of any State agency administering a State plan of operations pursuant to part D of this title, or upon the request of any State desiring to prepare and submit a plan of operations, any officer or employee of the Board (including any officer or employee detailed to the Board pursuant to subsection (d)) may be detailed by the Board to assist in the administration, or in the preparation, of such State plan of operations. The funds available for the Federal administration of this title may, in the discretion of the Administrator, be reimbursed from funds allotted to the State pursuant to section 272 and available for State administration, for the salary (or for the pay and allowances) of any officer or employee so detailed.

### ADVISORY COUNCIL

SEC. 252. (a) There is hereby established a National Advisory Medical Policy Council (referred to in this title as the "Advisory Council") to consist of the Chairman of the Board, who shall serve as Chairman of the Advisory Council ex officio, and sixteen members appointed by the Federal Security Administrator. At least eight of the sixteen appointed members shall be individuals who are familiar with the need for personal health services in urban or rural areas and who are representative of the interests of individuals eligible for benefits under this title, and at least six of the members shall be individuals who are outstanding in the medical or other professions concerned with the provision of services provided as benefits under this title and who are representative of the individuals, organizations, and other persons by whom personal health services will be provided. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of that term, and the terms of the members first taking office shall expire, as designated by the Administrator at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year after the date of appointment. The Advisory Council is authorized to appoint such special advisory technical or professional committees as may be useful in carrying out its functions, and the members of such committees may be members of the Advisory Council, or other persons, or both. Appointed Advisory Council members and members of technical or professional committees, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Administrator, but not exceeding $25 per day; and shall be entitled to receive actual and necessary traveling expenses and per diem in lieu of subsistence while so serving away from their places of residence. The Advisory Council, its appointed members, and its committees, shall be provided with such secretarial, clerical, or other assistance as may be provided by the Congress for carrying out their respective functions. The Advisory Council shall meet as frequently as the Board deems necessary, but not less than twice each year. Upon request by six or more members, it shall be the duty of the Chairman to call a meeting of the Council.

(b) The Advisory Council shall advise the Board with reference to matters of general policy and administration arising in connection with the making of regulations, the establishment of professional standards, and the performance of its other duties under this title.

### STUDIES, RECOMMENDATIONS, AND REPORTS

SEC. 253. The Board shall have the duty of studying and making recommendations as to the most effective methods of providing health services, and as to legislation and matters of administrative policy concerning health and related subjects. At the beginning of each regular session of Congress, it shall make a full report to Congress of the administration of this title, including a report with regard to the adequacy of the financial provisions contained in this title and of appropriations made pursuant thereto, the methods of allotment of funds among the States, and related matters. Such report shall include a record of consultations with the Advisory Council, recommendations of the Advisory Council, and comments thereon.

### NONDISCLOSURE OF INFORMATION

SEC. 254. Information concerning an individual, obtained from him or from any physician, dentist, nurse, or hospital, or from any other person pursuant to or as a result of the administration of this title, shall be held confidential (except for statistical purposes) and shall not be disclosed or be open to public inspection in any manner revealing the identity of the individual or other person from whom the information was obtained or to whom the information pertains, except as may be necessary for the proper administration of this title or of other laws, State or Federal. Any person who shall violate any provision of this section shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000 or by imprisonment not exceeding one year, or both.

### PROHIBITION AGAINST DISCRIMINATION

SEC. 255. In carrying out the provisions of this title, there shall be no discrimination on account of race, creed, or color. Personal health services shall be made available as benefits to all eligible individuals, and all persons qualified under part B to enter into agreements to furnish or provide such services shall be permitted to do so.

### RURAL AREAS

SEC. 256. (a) In the administration of this title special consideration shall be given to the problems of rural areas, and particularly of those areas in which shortages of the professional and technical personnel and facilities, needed to provide personal health services, operate to make unavailable or to restrict disproportionately the availability of health services. With respect to any rural area determined, as a result of the survey of personnel resources, facilities, and needs made in the State pursuant to section 202 (a) of this title, to be an area of need for personnel or facilities, the program developed in the State pursuant to that section shall contain special provisions for the alleviation of the shortages in such area, which may include—

(1) as an alternative method of payment for physicians, dentists, nurses, or other individuals furnishing personal health services, located in or settling in the area, a method guaranteeing a minimum annual income for services furnished as benefits: *Provided*, That any such guaranty may be conditioned upon an agreement to furnish preventive services at the request of public-health authorities in the area;

(2) provision (A) for defraying out of the account the reasonable expenses of transportation to the area for individuals establishing practice in the area, and (B) for loans from the account to such individuals for office equipment essential to their provision of personal health service benefits; upon condition that such individuals enter into agreements to furnish personal health services as benefits in the area for a specified minimum period;

(3) provision for adequate ambulance services in connection with hospitals serving the area, and for defraying out of the account the expense of unusually costly travel incurred by eligible individuals in obtaining essential personal health-service benefits, if such travel has been recommended by the attending physician or dentist and certified by the local administrative officer as essential to the individual's proper care;

(4) provision for disseminating throughout the area pertinent information on the preventive and diagnostic health services available in the area, and for such other special activities as may be appropriate to acquaint eli-

gible individuals in the area with the benefits available under this title, and the manner in which they may be obtained.

(b) The Board is authorized to make such regulations, after consultation with the Advisory Council, as may be necessary to promote and facilitate the accomplishment of the objectives of this section. In administering grants under section 273 for professional education, the Board shall give special consideration to the need for training personnel who will practice in rural areas, and for postgraduate training of personnel who are practicing or will practice in such areas. The Board shall include in its annual reports to Congress recommendations concerning such further legislative measures as it considers desirable to assure to rural people an equality of opportunity to obtain the personal health service benefits available under this title.

## PART F—ELIGIBILITY DETERMINATIONS, COMPLAINTS, HEARINGS, AND JUDICIAL REVIEW

### DETERMINATIONS AS TO ELIGIBILITY FOR BENEFITS

SEC. 261. (a) The Federal Security Administrator, through such units of the Federal Security Agency as he may determine, shall upon his own initiative or upon application of any individual make determinations as to the eligibility of individuals for benefits under this title. Whenever requested by any individual determined by the Federal Security Administrator not to be eligible for benefits for any period, or by a dependent of any such individual, the Administrator shall give such individual or such dependent reasonable notice and opportunity for a hearing with respect to such determination and on the basis of the evidence adduced at the hearing shall affirm, modify, or reverse his determination.

(b) In carrying out his responsibility under this section, the Administrator shall have all the powers and duties conferred upon him under sections 205 and 206 of the Social Security Act, as amended. Such powers and duties shall be subject to the same limitations and rights of judicial review as are contained in section 205 of such Act. Eligibility for benefits under this title based on entitlement to an annuity under the Civil Service Retirement Act, as amended, shall be determined on the basis of certification by the Civil Service Commission.

(c) Nothing in part D of this title shall be deemed to require or authorize any assumption by the State agency, designated in accordance with an approved State plan of operations approved under such part, of any of the Administrator's responsibilities under this section, but the Administrator may utilize existing facilities and services of any such agency on the basis of mutual agreements with such agency.

### COMPLAINTS OF ELIGIBLE INDIVIDUALS AND OF PERSONS FURNISHING BENEFITS

SEC. 262. (a) Any eligible individual aggrieved by reason of his failure to receive any personal health-service benefits to which he believes himself entitled, or dissatisfied with any service rendered him as a personal health-service benefit, and any person who has entered into an agreement to furnish services as personal health-service benefits and who is aggrieved by the failure or alleged failure of a local or other administrative officer or a local administrative committee to carry out the agreement in accordance with its terms, may make a complaint to the local administrative officer or local executive officer in the area in which the action or inaction complained of occurred, or to such other officer as may be provided in regulations. If the officer to whom such complaint is made finds, after investigation, that the complaint is well-founded, he shall prmoptly take such steps as may be necessary and appropriate to correct the action or inaction complained of; and he shall notify the individual or other person making the complaint of his disposition thereof. Any such individual or other person dissatisfied with the action taken may in writing request a hearing thereon and shall be afforded opportunity for the same pursuant to subsection (b) of this section.

(b) Provision shall be made for the establishment of necessary and sufficient impartial tribunals to afford hearings to individuals and other persons entitled thereto under subsection (a) of this section, or section 217 (d) of this title, and for further review of the findings, conclusions, and recommendations of such tribunals, in accordance with regulations made by the Board, after consultation with the Advisory Council. With respect to any complaint involving matters or questions of professional practice or conduct, the hearing body shall contain competent and disinterested professional representation; and with respect to any complaint involving only matters or questions of professional practice or conduct the hearing body shall consist exclusively of such professional persons.

(c) In administering this section in any State which has not assumed responsibility for the administration of benefits under this title as provided in part D, the Board (subject to the provisions of section 251 (b)) shall, insofar as they are applicable to its functions under this title, have all the powers and duties conferred upon the Federal Security Administrator by sections 205 and 206 of the Social Security Act, as amended. Such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 of such Act.

(d) In any State which has assumed responsibility for the administration of benefits under this title as provided in part D, the powers and duties of the State agency shall be subject to such rights of judicial review in the courts of the State as the law of the State may provide; subject, however, to review by the Supreme Court of the United States in such cases and in such manner as is provided in section 237 of the Judicial Code, as amended.

## Part G—Fiscal Provisions

### PERSONAL HEALTH SERVICES ACCOUNT

Sec. 271. (a) There is hereby created on the books of the Treasury of the United States a separate account to be known as the "Personal Health Services Account" (in this title, referred to as the "account"). Funds in the account not required for current withdrawals shall be invested by the Secretary of the Treasury in the types of obligations which may be acquired by the Federal Old-Age and Survivors Insurance Trust Fund, and in accordance with provisions governing such investments in section 201 (c) to (e), inclusive, of the Social Security Act, as amended. Funds in the account shall be available for all expenditures necessary or appropriate to carry out this title; except that (subject to the provisions of section 272 (g)) only so much of such funds shall be available for salaries or other administrative expenses of any department or agency of the United States as may be authorized in annual or other appropriation Acts.

(b) There shall be appropriated to the account for the fiscal year ending June 30, 1950, and for each fiscal year thereafter—

(1) sums equal to 3 per centum of all wages estimated to be received during such fiscal year;

(2) sums equal to the estimated cost of furnishing dental services and home-nursing services as personal health-service benefits during such fiscal year; and

(3) any further sums required to meet expenditures to carry out this title.

(c) There shall be appropriated to the account in the fiscal year 1949, a sum equal to 1 per centum of all wages estimated to be received during such fiscal year, to constitute on July 1, 1949, a reserve in the account for the purposes specified in section 272 (a).

(d) The aggregate appropriations to the account, pursuant to clauses (2) and (3) of subsection (b), in appropriation Acts for any fiscal year from 1950 to 1952, inclusive, shall not exceed one-half per centum, and in appropriation Acts for any fiscal year from 1953 to 1955, inclusive, shall not exceed 1 per centum sums which shall be available from the account for provision during the fiscal years preceding such fiscal year. Whenever an appropriation is made on the basis of an estimate of wages to be received during a fiscal year, the appropriations for subsequent fiscal years shall be adjusted by any amount by which such estimate was greater or less than the amount of wages actually received. Before January 1, 1955, and periodically thereafter, the Congress will review this title and will determine the amounts of appropriations to be made thereafter.

(e) Sums received as reimbursements to the account pursuant to section 204 (c) or section 205, or by virtue of subrogation pursuant to section 204 (c), shall be deposited in the account and shall be available in accordance with the provisions of subsection (a) of this section.

### ALLOTMENT OF FUNDS

Sec. 272. (a) The Board, after consultation with the Advisory Council, shall determine, as far in advance of the beginning of each fiscal year as possible, the sums which shall be available from the account for provision during the fiscal year of all classes, and of each of the five classes, of personal health-service benefits specified in section 201 (a). Such sums shall be determined, after taking into consideration the estimated amount which will be in the account at the beginning of the fiscal year and the anticipated income of the account thereafter, with a view (1) to maintaining as nearly as practicable a uniform rate of expenditure for personal health-service benefits in successive fiscal years, except for appropriate allowance on account of anticipated increase in the personnel and facilities available to furnish personal health-service benefits and on account of reduction or withdrawal of restrictions or limitations pursuant to section 202 (b), and (2) to establishing and maintaining a reserve in the account adequate to meet emergency demands in accordance with subsection (d) of this section and adequate to maintain the rate of expenditure or to permit its gradual reduction if the income of the account should fall below the income which had been anticipated.

(b) In accordance with regulations prescribed after consultation with the State agencies, the Board, prior to the beginning of each fiscal year, shall allot to the several States, for the fiscal years 1950, 1951, and 1952, 90 per centum, and for each fiscal year thereafter 95 per centum, of each sum determined pursuant to subsection (a). Such regulations shall provide for allotments on the basis of—

(1) the population in the several States eligible for benefits under this title;

(2) professional and other personnel, hospitals, and other facilities, and supplies and commodities, to be available in the several States in the provision of such benefits; and

(3) the cost of reasonable and equitable compensation to such personnel and facilities and for such supplies and commodities.

Such allotments shall operate, to the maximum extent possible, both to assure provision to eligible individuals of adequate personal health-service benefits in all States and all local health-service areas, and also to increase the adequacy of services where personnel and facilities are below the national average.

(c) From time to time during each fiscal year, the Board shall allot to the several States the remaining 10 per centum or the remaining 5 per centum, as the case may be, of each sum determined pursuant to subsection (a). In making allotments under this subsection, the Board shall take into consideration the factors specified in subsection (b), but shall, in addition, give special consideration to the extent to which allotments under subsection (b) have proved to be insufficient to permit provision of reasonably adequate benefits under this title.

(d) In addition to the sums determined pursuant to subsection (a) to be available for the provision of personal health-service benefits, the Board, after consultation with the Advisory Council, is authorized to make emergency allotments from the account if it finds that a disaster, epidemic, or other cause has substantially increased the volume of personal health-service benefits required in any part of the United States over the volume anticipated when the determinations pursuant to subsection (a) were made. Allotments pursuant to this subsection shall be made to such State or States, for such class or classes of personal health-service benefits, and in such amounts, as the Board may find necessary to meet the emergency.

(e) The Board shall from time to time determine the amounts to be paid to each State from its allotments under this section, and shall certify to the Secretary of the Treasury the amounts so determined. The Secretary shall thereupon, and prior to audit or settlement by the General Accounting Office, pay to the State the amounts so certified.

(f) Funds paid to a State for any class of personal health-service benefits shall be used exclusively for the provision of benefits of that class, except that the administrative costs of the State in administering personal health-service benefits under this title may be met from the allotments to the State. Such administrative costs, which in any fiscal year shall not exceed 5 per centum of the aggregate allotments to the State for such fiscal year, shall be apportioned as between the several allotments in accordance with the costs of administering the respective classes of benefits; and such apportionment may be made in such manner, and by such sampling, statistical, or other methods, as may be agreed upon between the Board and the State agency.

(g) In any case in which the Board has assumed responsibility for the administration in a State of benefits under this title in accordance with section 242 (d) or (e), all allotments or balances of allotments to such State shall be available for expenditure by the Board for the provision of personal health-service benefits in that State, and (until the Congress shall make funds available therefor pursuant to section 271 (a)) for the costs of administration of such benefits in such State. Expenditures authorized pursuant to section 271 (a) for such costs of administration shall be charged against allotments to such State.

### GRANTS-IN-AID FOR MEDICAL RESEARCH AND EDUCATION

SEC. 273. For the purposes of encouraging and aiding the advancement and dissemination of knowledge and skill in providing benefits under this title and in preventing illness, disability, and premature death. the Board is hereby authorized and directed to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. Such grants-in-aid shall be made with respect to each project (a) for which application has been received from a nonprofit institution or agency, stating the nature of the project and giving the reasons for the need of financial assistance in carrying it out, and (b) for which the Board finds, with the advice of the Advisory Council and after consultation with other Federal departments and agencies concerned with research or professional education, that the project shows promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, dental, nursing, hospital, or auxiliary services provided as benefits under this title, or to human knowledge with respect to the cause, prevention, mitigation, or methods of diagnosis and treatment of disease and disability. During the five-year period beginning July 1, 1949, the Board and the Advisory Council shall give preference and priority to grants-in-aid with respect to projects to aid veterans of World War II seeking postgraduate education as medical or dental practitioners or training for administration of personal health services, disability benefits, rehabilitation services, or related services. For the purposes of this section there shall be available for the fiscal year 1950 the sum of $10,000,000, for the fiscal year 1951 the sum of $15,000,000, and for each fiscal year thereafter an amount equal to 2 per centum of the amount expended for benefits under this title in the last preceding calendar year. Such grants-in-aid, in such amounts and for payment at such times as are approved by the Board, shall be certified for payment to the Secretary of the Treasury, who shall pay them from the account to the designated institutions or agencies.

## PART H—MISCELLANEOUS PROVISIONS

### DEFINITIONS

SEC. 281. As used in this title—

(a) The term "wages" means the sum of the following items, excluding any amount in excess of $3,600 received (or, in the case of income from self-employment, accrued) by any individual during any calendar year—

(1) all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash; except that such term does not include—

(A) the amount of any payment made to, or on behalf of, an employee under a plan or system established by an employer which makes provision for his employees generally or for a class or classes of his employees (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment), on account of retirement, or sickness or accident disability, or medical and hospitalization expenses in connection with sickness or accident disability, or death; provided, in the case of a death benefit, that the employee (i) has not the option to receive, instead of provision for such death benefit, any part of such payment or, if such death benefit is insured, any part of the premiums (or contributions to premiums) paid by his employer, and (ii) has not the right, under the provisions of the plan or system or policy of insurance providing for such death benefit, to assign such benefit, or to receive a cash consideration in lieu of such benefit either upon his withdrawal from the plan or system providing for such benefit or upon termination of such plan or system or policy of insurance or of his employment with such employer;

(B) the payment by an employer (without deductions from the remuneration of the employee) of any social-insurance taxes or contributions imposed upon an employee; or

(C) the value of services exchanged for other services for which there is no payment other than the exchange; and

(2) all net income from farm, business, professional, or other self-employment.

(b) The term "employment" means any service of whatever nature performed by an employee for the person employing him, irrespective of the citizenship or residence of either, (A) within the United States, or (B) on or in connection with an American vessel or an American civil aircraft under a contract of service which is entered into within the United States or during the performance of which the vessel or aircraft touches at a port or airport in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, except—

(1) service in the active military or naval service of the United States;

(2) service performed in the employ of a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned by one or more States or political subdivisions;

(3) casual labor not in the course of the employer's trade or business;

(4) service performed by an employee on or in connection with a vessel not an American vessel, or an aircraft not an American aircraft, if the employee is employed on and in connection with such vessel or aircraft when outside the United States;

(5) service performed by a duly ordained or duly commissioned or licensed minister of any church in the regular exercise of his ministry and service performed by a regular member of a religious order in the exercise of duties required by such order;

(6) service performed by an individual as an employee or employee representative as defined in section 1 of the Railroad Retirement Act of 1937, as amended;

(7) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 101 of the Internal Revenue Code; if—

(A) the remuneration for such service does not exceed $45; or

(B) such service is in connection with the collection of dues or premiums for a fraternal beneficiary society, order, or association, and is performed away from the home office or is ritualistic service in connection with any such society, order, or association; or

(C) such service is performed by a student who is enrolled and is regularly attending classes at a school, college, or university;

(8) service performed in the employ of a foreign government (including service as a consular or other officer or employer or a nondiplomatic representative);

(9) service performed in the employ of an instrumentality wholly owned by a foreign government; if—

(A) the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) the Secretary of State shall certify to the Federal Security Administrator that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof: and

(10) service performed in the employ of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act.

(c) In any case in which an individual has received $3,600 in wages in a calendar year, not less than $150 of such wages shall be deemed, for the purpose of section 204 (a), to have been received by him in the quarter during which the first of such wages were in fact received by him and in each quarter of such calendar year thereafter.

(d) The term "benefit year" means a period commencing on July 1 of any year and ending on June 30 of the succeeding year.

(e) The term "quarter" and the term "calendar quarter" mean a period of three calendar months ending on March 31, June 30, September 30, or December 31.

(f) The term "employee" includes (in addition to any individual who is a servant under the law of master and servant) any individual who performs service, of whatever nature, for a person, unless the service is performed by the individual in pursuit of his own independently established business. The term "employee" also includes an officer of a corporation.

(g) The term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented nor numbered under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

(h) The term "American aircraft" means an aircraft registered under the laws of the United States.

(i) The term "State" includes Alaska, Hawaii, and the District of Columbia.

(j) The term "United States," when used in a geographic sense, means the several States as defined in subsection (i).

(k) The term "dependent" means an unmarried child (including a stepchild, adopted or foster child) of an individual, who is under the age of eighteen, or who is under a total disability which has continued for a period of not less than six consecutive calendar months and is living with such individual or receiving regular support from him; a wife of an individual living with such individual or receiving regular support from him; a husband who is under a total disability which has continued for a period of not less than six consecutive calendar months, and is living with or receiving regular and substantial support from such individual; and a parent who is living with or receiving regular and substantial support from such individual.

(l) The term "person" means an individual, a trust or estate, a partnership, a corporation, an association, a consumer cooperative, or other organization.

### AVAILABILITY OF PUBLIC-ASSISTANCE GRANTS FOR SECURING PERSONAL HEALTH BENEFITS

SEC. 282. In order that Federal grants to States for old-age assistance, aid to dependent children, and aid to the blind shall be available to the States for provision of benefits for noninsured needy individuals, as provided in section 205—

(a) Title I of the Social Security Act, as amended, is amended—

(1) By amending section 6 to read:

"SEC. 6. When used in this title the term 'old-age assistance' means money payments to needy aged individuals, and reimbursements to the Personal Health Services Account with respect to needy aged individuals.";

(2) By striking out in section 3 (a) "not counting so much of such expenditure" and inserting in lieu thereof "not counting so much of any money payment"; and by striking out in clause (A) of such subsection "who received old-age assistance" and inserting in lieu thereof "who received money payments".

(b) Title IV of such Act is amended—

(1) By amending section 406 (b) to read:

"(b) The term 'aid to dependent children' means money payments, and reimbursements to the Personal Health Services Account, with respect to a dependent child or dependent children.";

(2) By striking out in section 403 (a) "not counting so much of such expenditure" and inserting in lieu thereof "not counting so much of any money payment"; and by striking out in clause (A) of such subsection "with respect to whom aid to dependent children is paid" and inserting in lieu thereof "with respect to whom money payments are made".

(c) Title X of such Act is amended—

(1) By amending section 1006 to read:

"SEC. 1006. When used in this title the term 'aid to the blind' means money payments to blind individuals who are needy, and reimbursements to the Personal Health Services Account with respect to blind individuals who are needy."

(2) By striking out in section 1003 (a) "not counting so much of such expenditure" and inserting in lieu thereof "not counting so much of any money payment"; and by striking out in clause (A) of such subsection "who received aid to the blind" and inserting in lieu thereof "who received money payments".

### EFFECTIVE DATE

SEC. 283. The effective date of this title shall be the date of its enactment, but personal health services shall first become available as benefits in accordance with this title on July 1, 1949.

# TITLE III—DEVELOPMENT AND EXPANSION OF HEALTH SERVICES

## PART A—GRANTS TO STATES FOR HEALTH SERVICES

### PURPOSES

SEC. 301. (a) The purpose of this part is to enable each State to

(1) expand its basic State and local public health organization and the basic services provided thereby, in order that such services, together with all other services provided through such organization, may be made readily available in all communities in the State;

(2) establish and maintain adequate maternal and child health services, and particularly services for locating and caring for crippled or otherwise physically handicapped children;

(3) establish and maintain adequate health services for the early detection, prevention, treatment, and control of tuberculosis, venereal diseases, mental disorders, cancer, heart and degenerative diseases, dental disorders, nutritional deficiency diseases, or other diseases or conditions which have a high morbidity or mortality incidence or which require extensive care or specialized therapy;

(4) establish and maintain adequate health services for the aged, the chronically ill, workers in industry and other groups in whose health or health problems the public has a special interest or responsibility; and

(5) provide training for personnel engaged or to be engaged in administering or furnishing services provided pursuant to this title, and to develop, promote, and demonstrate more effective measures for carrying out the purposes of this title.

(b) As used in subsection (a) of this section, "health services" include the provision of medical, nursing, dental, and hospital care and related services to individuals in the categories mentioned, to the extent that such care or services are not otherwise available to such individuals under title II of this Act, and includes with respect to impairments and diseases specifically mentioned, measures for the prevention, diagnosis, treatment, and control of the same.

### GRANTS TO STATES

SEC. 302. To assist the States and the counties, health districts, and other political subdivisions of the States in carrying out the purposes set forth in section 301 of this title, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, the sum of $100,000,000; for the fiscal year ending June 30, 1949, the sum of $150,000,000; for the fiscal year ending June 30, 1950, the sum of $225,000,000; for the fiscal years ending June 30, 1951, and June 30, 1952, the sum of $300,000,000 each; and for succeeding years sums sufficient to carry out the purposes of this section. The sums made available under this section shall be used for making payments to States which have submitted and had approved under section 304 State plans for carrying out such purposes.

### SERVICES TO STATES

SEC. 303. To enable the Federal Security Administrator (a) to assist the States by developing, promoting, and demonstrating more effective measures for carrying out the purposes of this part, by conducting investigations, studies, and research in preventive treatment or control measures, and by providing, through the Public Health Service or the Children's Bureau or through grants to public or other nonprofit institutions, training in the administration or the provision of health services to be furnished under this title, and (b) to pay the salaries, allowances, and travel expenses of commissioned officers and other personnel of the Public Health Service and the Children's Bureau detailed to assist the States in carrying out the purposes of this part, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subsection.

### STATE PLANS

SEC. 304. (a) Any State desiring to take advantage of the provisions of section 302 may do so by submitting and having approved a State plan or plans for carrying out the purposes of section 301. Any such State plan must—

(1) provide for the establishment or designation of a single State health agency to administer or supervise the administration of the plan which, insofar as feasible, shall be the same State agency which administers or supervises the administration of the benefits provided under title II of this Act, and provide, in the case of a State plan to carry out any of the purposes of clause (2) of section 301 (a), for the administration or supervision of administration of such plan, not later than the end of the fourth year after the date of enactment of this Act, by the same State health agency which administers or supervises the administration of any other State plan to carry out any other of the purposes of that clause;

(2) provide for substantial financial participation by the State;

(3) provide for the training of personnel engaged or to be engaged in administering or providing health services under the plan;

(4) provide for the progressive extension and improvement of the services provided under the plan so that, within ten years after approval of the State's first such plan under this section, such services will be available in each political subdivision the State and, in the case of any plan to carry out the purposes of clause (1) of section 301 (a), there will be a full-time local or district health organization providing basic health services in each political subdivision of the State;

(5) provide for State standards for services to be furnished to individuals under the plan, including standards for professional personnel rendering medical, dental, nursing, and related types of care or services, and standards for hospital and other institutional care and services;

(6) provide that in carrying out the plan there will be no discrimination on account of race, color, creed, citizenship, or economic status, and for granting an opportunity for a hearing before the State agency to any individual denied any services under the plan and to any person or organization participating or desiring to participate in furnishing services under the plan;

(7) provide such methods of administration, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Federal Security Administrator shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Federal Security Administrator to be necessary for the proper and efficient operation of the plan;

(8) provide safeguards which restrict the use and disclosure of information concerning individuals receiving or providing services under the plan to purposes directly connected with the administration of the plan;

(9) provide that the State agency will cooperate with medical, dental, hospital, nursing, health, educational, and welfare groups or organizations in the State, and will cooperate, including where necessary entering into working agreements, with other public agencies administering or providing services related to those furnished under the plan;

(10) provide for the designation of an advisory council or councils and for technical advisory committees, as necessary, to consult with the State agency in carrying out the plan, such councils and committees to be composed of representatives of public and private agencies or organizations administering related programs, of persons chosen from the professions whose members furnish services under the plan, and, in the case of the councils, of representatives of the public selected from persons who are informed on the need for the services provided under the plan;

(11) provide that the State agency will make such reports, in such form and containing such information, as the Federal Security Administrator may from time to time reasonably require and will give him access to the records upon which such information is based;

(12) indicate the purpose or purposes, from among those set forth in section 301, which will be carried out under the plan, and provide, for each fiscal year during which the plan shall be in effect, a program for carrying out each such purpose. Such program shall include a financial plan of the total sums to be expended for each such purpose under the program during the fiscal year reasonable assurance by the State agency that it will expend for the program a sum approximately equal to that so estimated.

(b) The Federal Security Administrator shall approve any State plan, or modification of a State plan, which he finds complies with the provisions of subsection (a), except that he shall not approve any plan containing any requirement under which any person living in the State would be denied any services under the plan on account of place or length of residence. After initial approval of a plan, no change required pursuant to this title shall be effective prior to the July 1 next succeeding the making of such requirement, except with the consent of the State or in accordance with further action by Congress.

(c) In the event of his disapproval of any plan or any modification of a plan submitted by a State pursuant to this part, the Federal Security Administrator shall notify the State of such disapproval, and shall, upon request of the State, afford it reasonable notice and opportunity for a hearing on such disapproval.

### ALLOTMENTS

SEC. 305. From the total sums appropriated under section 302 for each fiscal year, the Federal Security Administrator shall, as far in advance of the beginning of each fiscal year as possible and from time to time during each fiscal year, make allotments of such sums among the States in accordance with regulations prescribed by him. Such regulations shall provide for the making of allotments on the basis of (a) the population of the respective States, and (b) their financial resources. Such regulations shall also provide that the allotment for any State may be reduced to the extent that any amount estimated in the State's plan or plans to be expended thereunder for carrying out any one or more of the purposes in section 301, exceeds an amount fairly representing the need in such State for carrying out such purpose or purposes (as compared with the need for carrying out other purposes set forth in section 301, and with the amounts, if any, it estimates it will expend for such other purposes under plans submitted pursuant to this section). Upon making allotments under this section, the Federal Security Administrator shall thereupon notify the Secretary of the Treasury and each State of the amount of its allotment under this section.

### PAYMENTS TO STATES

SEC. 306. (a) From the allotment available therefor under section 305, the Secretary of the Treasury shall from time to time pay to each State which has an approved plan for carrying out one or more of the purposes set forth in section 301 an amount, which shall be used exclusively for carrying out the State plan, equal to the Federal percentage of the total sums expended under the State plan during the period for which such payment is made.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Federal Security Administrator shall from time to time, but not less often than semiannually, estimate the amount to be paid to the State from its allotment under the provisions of subsection (a), such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended during the period for which the estimate is made in accordance with such subsection, including an estimate of the State and local funds to be expended, and (B) such other data as to estimated expenditures, and such investigations as the Administrator deems necessary.

(2) The Federal Security Administrator shall then certify the amounts so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by the amounts by which he finds that estimates of required expenditures for any prior period were greater or less than the actual expenditures for such period. Upon receipt of such certification, the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay in accordance with such certification.

### FEDERAL PERCENTAGE

SEC. 307. For the purposes of this part—

(a) the "Federal percentage" for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States, except that (1) the Federal percentage shall in no case be more than 75 per centum or less than 50 per centum, and (2) until per capita income data are regularly available for Alaska, Hawaii, Puerto Rico, or the Virgin Islands, the Federal percentage for Alaska and Hawaii shall be 50 per centum each, and the Federal percentage for Puerto Rico and the Virgin Islands shall be 75 per centum, and thereafter the Federal percentage for each shall be computed as for a State;

(b) the Federal percentages shall be promulgated by the Federal Security Administrator between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Federal Security Administrator shall promulgate such percentages as soon as possible after the enactment of this Act to be effective until July 1, 1949;

(c) the term "continental United States" does not include Alaska, Hawaii, Puerto Rico, or the Virgin Islands.

### OPERATION OF STATE PLANS

SEC. 308. Whenever the Federal Security Administrator, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a State plan, finds that, with respect to money paid the State for carrying out such plan from appropriations pursuant to section 302, there is a failure to comply substantially with—

(a) the provisions of this part;

(b) the provisions of such plan or the provisions required by section 304 (a) to be included in such plan;

(c) the regulations issued pursuant to this part;

he shall notify such State agency that further payments will not be made to the State from appropriations under such section (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be any such failure. Until he is so satisfied, the Federal Security Administrator shall make no further certification for payment to such State from appropriations under such section, or shall limit payment to activities in which there is no such failure.

### REGULATIONS

SEC. 309. The Federal Security Administrator shall prescribe such regulations as may be necessary to carry out his functions under this title. All such regulations or amendments of regulations with respect to grants to States shall be prescribed only after consultation with a conference of representatives of the State agencies administering or supervising the administration of any of the plans affected by such regulations or amendments. Insofar as practicable, the agreement of such representatives to the regulations or amendments shall be obtained prior to their issuance.

### ADMINISTRATION

SEC. 310. The Federal Security Administrator shall perform the functions with which he is charged under this title through the Public Health Service, the Children's Bureau and such other units of the Federal Security Agency as he may determine, and he may delegate such functions to officers and employees of the Agency.

### ANNUAL REPORT

SEC. 311. The Federal Security Administrator shall include in his annual report to Congress a full account of the administration of this part, including a record of consultations with conferences of representatives of the State agencies administering or supervising the administration of plans approved under this title, the recommendations of such conferences, and comments thereon.

### DEFINITIONS

SEC. 312. As used in this title, the term "State" means a State, the District of Columbia, Alaska, Hawaii, Puerto Rico, or the Virgin Islands.

### REPEAL AND TRANSITION PROVISIONS

SEC. 313. (a) Parts 1 and 2 of title V of the Social Security Act, as amended, and section 314 of the Public Health Service Act, as amended, are hereby repealed.

(b) If any State cannot on date of enactment of this Act fully comply with the conditions required by this title for payments from the appropriations under section 302, such State may receive such payments until sixty days after the legislature of such State first meets in due course after such date of enactment or until the earliest effective date after such sixty days which could be given in such State to legislation passed within such sixty days to secure such payments, whichever is the later, if such State complies with such conditions to the extent possible. In the case of any State in which a State plan for services to crippled children approved under part 2 of title V of the Social Security Act provides, immediately prior to the enactment of this Act, for administration or supervision of administration of such plan by a State agency other than a State health agency, the plan of such State to carry out the purposes of section 301 (a) (2) of this Act with respect to services for crippled children may provide for administration or supervision of administration of the plan with respect to such purposes by such other agency, but only until the end of the fourth year after the enactment of this Act, and until the end of such fourth year such a provision shall be deemed to comply with the requirements of paragraph (1) of section 304 (a).

## PART B—CONSTRUCTION OF HEALTH FACILITIES

### AMENDMENTS OF HOSPITAL SURVEY AND CONSTRUCTION ACT

SEC. 321. (a) Section 621 of the Public Health Service Act (as added by the Hospital Survey and Construction Act) is amended to read as follows:

### "AUTHORIZATION OF APPROPRIATIONS

"SEC. 621. In order to assist the States in carrying out the purposes of section 601 (b), there are hereby authorized to be appropriated for the fiscal year ending June 30, 1947, the sum of $75,000,000, and for the fiscal year ending June 30, 1948, and for each of the eight succeeding fiscal years the sum of $100,000,000 for the construction of public and other nonprofit hospitals; and there are further authorized to be appropriated for such construction the sums provided in section 624. The sums appropriated pursuant to this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for carrying out the purposes of section 601 (b); and for making payments to political subdivisions of, and public or other nonprofit agencies in, such States."

(b) Paragraph (5) of section 623 (a) of such Act is amended by striking out the words "and for maintenance and operation".

(c) Section 624 of such Act is amended by strking out the words 33⅓ per centum", in the second sentence of such section, and inserting in lieu thereof the words "such State's allotment percentage".

(d) Subsection (a) of section 625 of such Act is amended by striking out the words "and for its maintenance and operation when completed" from clause (4); and by striking out the words "33⅓ per centum" in the third sentence of such subsection and inserting in lieu thereof the words "the State's allotment percentage".

(e) Subsection (b) of section 625 of such Act is amended by striking out the words "33⅓ per centum" in the first sentence of such subsection and inserting in lieu thereof the words "the State's allotment percentage".

(f) Subsection (e) of section 625 of such act is amended by striking out the words "33⅓ per centum" and by inserting in lieu thereof the words "the State's allotment percentage".

(g) This section, and all amendments to the Public Health Service Act made by this section, shall become effective July 1, 1947. State plans approved by the Surgeon General pursuant to section 623 of that Act prior to July 1, 1947, shall not solely by virtue of such amendments, or any changes in regulations made necessary thereby, be deemed not to conform with title VI of that Act or regulations made thereunder but such plans may with the consent of the State and with the approval of the Surgeon General be modified retroactively to take full advantage of the amendments made by this section.

Senator SMITH. The committee will come to order.

I will make a brief preliminary statement.

This is a hearing on S. 545, a bill introduced by the Senator from Ohio, Mr. Taft, for himself, the Senator from Minnesota, Mr. Ball, the Senator from Missouri, Mr. Donnell, and myself, the Senator from New Jersey.

The purpose of the bill is as stated in the title, to coordinate the health functions of the Federal Government in a single agency; to amend the Public Health Service Act for the following purposes: To expand the activities of the Public Health Service; to promote and encourage medical and dental research in the National Institute of Health and through grants-in-aid to the States; to construct in the National Institute of Health a dental research institute, and for other purposes.

It is our present plan to hold hearings on this bill for 4 to 5 weeks on Wednesdays, Thursdays, and Fridays, with the exception of Memorial Day, May 30, for the purpose of concluding if possible the hearings as soon as we can after June 15.

Many witnesses have asked to be heard and therefore it will be necessary to limit strictly the time of those appearing before the committee. It is requested that all witnesses present the substance of their proposals and arguments in concise form.

I quote here section 133 (e) of the La Follette-Monroney Reorganization Act which provides:

> Each standing committee shall, so far as practicable, require all witnesses appearing before it to file an advance written statement of their proposed testimony and to limit their oral presentation to brief summaries of their arguments.

Last year's hearings were held by the Education and Labor Committee of the Senate of the Seventy-ninth Congress on the so-called Wagner-Murray-Dingell bill, which provides for over-all health programs and specifically emphasizes compulsory health insurance plans.

The principal issue before the committee, this committee, will be the relative merits and workability of compulsory health insurance plans or voluntary health insurance plans.

Another difference in the approach to the two pieces of legislation is that the Wagner-Murray-Dingell bill tends to concentrate authority and control in the Federal Government and presents an over-all planning program with which the various States of the Union are to conform if they are to enjoy the benefits of the act.

S. 545, on the other hand, which is before us at the present time, endeavors to decentralize the national health program by challenging the respective States to develop their own programs with a minimum set of conditions under which a State can expect to benefit from Federal grants-in-aid.

S. 545 does not seek uniformity but rather a continuing trial and error experiment in the 48 States which will lead to constantly improving procedures.

It is admitted by all that there is a Federal responsibility for the health of our people, and that with the rising cost of medical care because of the advances of science, we need to discover ways and means of assisting, especially those in the lower income brackets, by some program of health aid.

It is to explore these types of programs that these hearings are to be held with the hope and expectations that in our deliberations we will be able by amendments and improvements to develop all pending bills to recommend an ultimate measure or measures that Congress can support.

Today we are honored to have with us the chairman of the Senate Committee on Labor and Public Welfare, the Senator from Ohio, Mr. Taft, who is the principal sponsor of S. 545 and who will be our first witness.

Senator Taft, we will be glad to hear from you on S. 545.

Senator MURRAY. Mr. Chairman, before you proceed with the hearings, I would like to make a brief statement with reference to the arrangements for the witnesses at this hearing.

I feel it is necessary for me to call your attention to this situation.

The organizations scheduled to testify on this bill have been chosen without any consultation with the minority party members of the subcommittee and in a manner directly contrary to the established precedents.

You will recall that Senator Donnell just a few days ago appointed a subcommittee for the purpose of arranging the hearings on the FEPC. That is the general practice in the Senate in all committees. We have always followed it in this committee.

More than nine-tenths of the allotted time has been given over to organizations, almost all of which represent doctors and hospitals—less than 1 percent of the people who would be affected by this legislation. Less than 2 hours of time has been allowed for organizations representing the millions expected to be opposed to the principles of this bill. The schedule was adopted without any of these organizations being given notice of when the hearings would be held.

On the other hand, this committee has sent out notices long ago. I have a statement here which was issued by Marjorie Shearon to the people interested in this legislation on May 9, 1947, in which she states: "At the request of Senator Smith, I am discontinuing my news releases." And she goes on to state the situation with reference to the hearings on this bill, notifying them what the procedure is going to be and so forth.

But, we had no notice whatever of that. The whole thing was acted upon without consultation with the minority members.

I would like to have that statement of Marjorie Shearon put in the records.

(The statement referred to is as follows:)

MAY 9, 1947.

TO MY READERS: At the request of Senator Smith I am discontinuing my news releases.

As I stated at the time, I accepted the appointment as consultant with reluctance and misgivings. Both have increased. For some time I have been considering other plans. When they have been completed I shall notify you.

Since I notified you 10 days ago that hearings on S. 545 would begin on May 21, there has been a period of uncertainty as to further plans. I finally received the green light this morning at the first full session of the Health Subcommittee on Labor and Public Welfare. Today I am issuing official invitations for specific days.

The new WMD bill will be introduced on May 12. Hearings on that bill will follow immediately after those on S. 545. I have a list of 42 witnesses to be heard on the WMD bill. I am now arranging the schedule within the limitations of possibly nine sessions for S. 545 and six for the WMD bill. Senator Smith would like to keep the hearings for the two bills within a 4-week period. I do not see how that is possible.

At long last there is to be a congressional investigation of several situations in the FSA. The House Committee on Expenditures in the Executive Departments has just set up a Subcommittee on Publicity and Propaganda in such departments. My Blueprint is to be made the basis of the first investigation. Obviously I can be of some real service in this connection.

Not being able to write personal letters in the quantity required, I adopted the weekly releases. Now that these are to be discontinued there will be no way to communicate with you except very occasionally. The accounts of those who have sent stamps will be adjusted as soon as I am able to attend to the matter.

I am going ahead with the third printing of the Blueprint, and shall continue to fill orders. The pamphlet becomes of especial importance in view of the introduction of the new WMD bill.

I should like to take this occasion to thank you for many kind expressions of interest in what I have endeavored to do in the public interest. Pressure groups have been trying for months to have me silenced. It is important to them that I should not present the facts about political developments affecting medicine, especially at this time. At this moment my only comment is that during the 35 years of my professional life, I have never made any decision as to my own next step on the basis either of expediency or of financial rewards. In the few remaining years of my professional career I shall not change a lifetime pattern regarding my own conduct. I think the issues at stake are of very great importance. I do not intend to play a passive or negative role.

MARJORIE SHEARON, Ph. D.,
*P. O. Box 4034, Chevy Chase 15, Md.*

Senator MURRAY. The bill starts, the bill that we are hearing this morning, with a very fine comment. It calls itself "The National Health Act" and it pretends to assure medical care to all the people of this nation. In its preamble, the bill makes an encouraging reference to the desirability of making medical services available "to every individual regardless of race or economic status."

Actually, it only makes limited medical services available and only to people willing to accept public charity.

To give medical care with public funds to that small fraction of our population who have little or no income and who are supported by public agencies anyway, is reasonable and necessary, and this bill sets up an appropriation barely sufficient to supply medical care to this bottom 4 or 5 percent of our people.

But this bill sets itself up to solve the national health problem. If the American people were to accept this odious principle of charity, which I am sure they will not, this bill would start us on the road to high appropriations from both Federal and State treasuries. Its medical services would be tax-supported and run by the government supporting them. This is the road to totalitarianism; a people dependent on the state. This bill inevitably means state medicine and Government regimentation of the medical profession.

The self respecting American way is to meet the health problem and to avoid staggering tax burdens in the way of insurance, as recommended by President Roosevelt in his administration and President Truman in his administration. Presumably fair opportunity to testify will be given opponents and proponents of health insurance later in these hearings. We must insist that fair opportunity be given during these hearings to bring out the glaring contrasts between the exaggerated claims of S. 545 and what it actually offers.

Now, I have telegrams here from two people—the Cooperative Health Federation which writes as follows:

> Cooperative Health Federation of America wishes time testify re S. 545 and other health bills. Our representatives, John Carson, Washington representative, Horace Hansen, legal counsel, Jerry Voorhis, cooperative league. Appreciate your help in scheduling. Cooperative Health Federation Gwen Goodrich, Acting Executive Secretary.

Also a telegram from William Green, president of the American Federation of Labor, which reads as follows:

> Urge you as member subcommittee of Senate Committee on Labor and Public Welfare holding hearings on proposed health legislation to insist on right of all interested groups to be heard on all proposals now before subcommittee. The American Federation of Labor protests what appears to be the plan of the subcommittee to confine hearings during next four weeks to proponents of Senate Bill 545. We wish to present our views on S. 545 as well as on health insurance. William Green, President, American Federation of Labor.

Senator SMITH. I may say, Senator Murray, in that connection that we advised Mr. Green that I think it is the 18th of June we have set aside for him to appear with others of his group.

I only have one brief comment to make. I was surprised at the opening statement of Senator Murray with regard to the first comment he made.

We had a meeting in our office last week at which we discussed the schedule for witnesses, and Senator Murray was told that he was to be given such time as he needed for his witnesses. There was no intention in any way, shape, or form to preclude witnesses.

We have to limit people in the time we give them. Of course we cannot go on holding hearings all summer.

Senator MURRAY. No.

Senator SMITH. But, within reason and with the cooperation of the entire committee.

I am sorry the statement was made that we have not cooperated. I am very apologetic if that seems to be the case and I repeat that we are going to give everybody opportunity within reason to be heard.

Senator MURRAY. Mr. Chairman, the list of witnesses that has been prepared and submitted here for these hearings is confined to witnesses supporting it, and they have not made any provision for witnesses opposing it. Heretofore, we have always followed the practice of interspersing these witnesses, having some appear for a bill and some against it. We have always followed that and I have acceded to the requests, when I was chairman of the committee, of the minority members to bring in their witnesses when it was convenient for them. I never tried to have all——

Senator SMITH (interposing). It was my impression, Senator Murray, that we would first present the proponents of the bill, and then the opponents of it at a later date in the hearings. I thought that was your understanding and desire from our discussion.

Senator MURRAY. That was true on the national insurance bill but with reference to this particular bill, it seems to me that people should be permitted to appear here and testify in respect to this bill, S. 545 and not confine us entirely to witnesses who are going to merely support the national insurance.

Senator SMITH. I assumed that your witnesses would come in and testify against this bill. I assumed that right along. I never had any question in my mind about that.

I think there is a misunderstanding between you and me in this matter. In my office we brought out clearly that we would put on the proponents and that you and Senator Pepper as minority members would have a chance to put on the opponents. Then you would have a chance to present an alternative bill.

I was trying to be fair in getting an orderly procedure.

Senator MURRAY. We had no notice of what was going on because this letter from Marjorie Shearon here indicates that the proponents of this bill were being well advised and well taken care of and well provided for this hearing, without consulting us or giving us any opportunity.

Now, it seems to me that any member of this staff should be totally impartial and should not be connected with any outside propaganda movement. I think it has been utterly unfair to have this staff member, a member of the staff of this committee to be acting in this manner, carrying on propaganda on the outside, and at the same time purporting to represent this committee.

It is contrary to the provisions of the Reorganization Act. She should be totally impartial, totally working for this committee and not for any outside interests.

Therefore, I think it was utterly unfair for her to make all these arrangements without ever calling us into consultation.

Here is her letter and I would like to have it printed in the record in connection with my statement.

Senator TAFT. I don't want to interrupt this battle but I have to go to a conference on the labor bill and I would like to make my statement—it is only a short one—and get through with it.

Senator SMITH. We appreciate your being here, Senator, and we know you are very busy in these other conferences.

## STATEMENT OF HON. ROBERT A. TAFT, A UNITED STATES SENATOR FROM OHIO

Senator TAFT. Of course, this bill and the so-called Murray-Wagner-Dingell bill are just two completely opposite and conflicting plans, and what the committee ultimately has to decide is whether they want one or the other.

We had hearings last year which were predominantly for the purpose of permitting the advocates of the Murray-Wagner-Dingell bill to appear. The opponents also appeared but the proponents of the Murray-Wagner-Dingell bill had certainly a most comprehensive presentation of their point of view.

What I desire, as a sponsor of this bill, is that this committee now hear some of the sponsors of this kind of medical plan instead of the other plan.

Of course, I think they were entitled to be heard first on theirs last year, presenting their case completely, in full, and no hearings being held on this bill except just at the end.

Senator MURRAY. Senator, permit me to interrupt you.

Senator TAFT. Yes.

Senator MURRAY. Of course, Senator, you appreciate the fact that all through those hearings the witnesses were interspersed. Whenever the opposition asked for witnesses to be heard, they were heard right along.

Senator TAFT. It was predominantly set up to put over the Wagner-Murray-Dingell bill as a piece of propaganda from the beginning.

Senator MURRAY. But, the majority of the——

Senator TAFT (interposing). You had your case; we have our case. I have been with this committee for a long time and the chairman of this committee has used the committee as a propaganda agency to put over the things that the chairman wanted.

Senator MURRAY. I wish to state that is utterly false.

Senator TAFT. Well, under present conditions——

Senator MURRAY (interposing). That is just in line with your attitude all the way along.

Senator TAFT. Under present conditions, we should present our case fully, giving, of course, full opportunity to the other side to answer, as you gave in the end. However——

Senator MURRAY (interposing). I gave every witness an opportunity to be heard and always consulted the other side for the presentation of their testimony.

Senator TAFT. When I think how every labor bill was suppressed during those years in which your party maintained and you were chairman, and when I think of the general procedure of this committee to put across that general plan, I certainly am surprised at the attitude you have taken this morning when we take the opportunity, when we have control of the committee, to present our case first. And that is all that is being done at the present time.

Senator SMITH. That will be the order of business of the committee.

Senator PEPPER. It is not a true statement for the Senator from Ohio to make that this committee suppressed labor legislation in an improper way.

Senator TAFT. Only for 8 years while I was a member of the committee.

Senator PEPPER. I thank God that some of us are proud to be associated with the defense of labor and not identified with its destruction.

Senator DONNELL. I move the regular order and that we proceed with the testimony.

Senator TAFT. Mr. President, the general plan of this bill is, as contrasted with the other plan, an attempt to improve the health services of the United States through a development and an assimilaion of the existing system of medical care in the United States rather than a substitution of a nationalized medical-care system for the existing systems.

That is the main purpose of this bill. It proceeds on the general theory of presenting Federal aid, of offering Federal aid to those States which make comprehensive plans to provide medical service, and to develop the existing system of medical service.

Now, this morning, I do not want to deal with the general conception of the National Health Agency, on which, no doubt, you will hear a good deal of discussion, and on which there is always tremendous interest.

I want to deal primarily with the general program which appears on page 16 of the bill, starting on line 16.

Senator SMITH. You are referring, Senator Taft, to part B?

Senator TAFT. Yes; part B.

Senator SMITH. Medical-care services?

Senator TAFT. That is right; which is the alternative, we may say, to national health insurance.

The national health insurance bill was introduced yesterday. I have not had an opportunity to read it or to know exactly how it may differ from the plan last year. But, from what I see in the paper, it assumes a general pay-roll tax of 4 percent to provide a great national health and insurance fund which is to be used to give medical care to all the people in the United States.

This bill is based primarily on State aid. That is, it offers aid to a State which, on page 18, submits a plan which sets forth a State-wide program designed and calculated to provide, within 5 years, hospital services, surgical services, and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such services.

And, also, periodical physical examinations are provided for all children in elementary and secondary schools in the State.

Senator SMITH. You are reading now from page 18?

Senator TAFT. Page 18.

Our medical care system today is a State and local system. Undoubtedly, under our constitutional system, the first responsibility for providing medical care rests on the State and local districts. It is their obligation to provide medical care for those who are unable to provide for themselves. It has been a recognized obligation of all American communities for a great many years.

I think the testimony shows that that has not been completely performed—that there are gaps in that service, gaps particularly in the poorer States, in the rural districts.

The proposal here is that a State may come in and say, "Now, we realize that this present system does not cover all those unable to pay for medical care, and is not complete, but here is a complete plan to do it and we are prepared to put up a certain amount of money for that purpose."

They can then get their share of the Federal aid in order to put that whole system into effect in order that it may be comprehensive and that all persons unable to pay for medical care may receive such care.

That is, of course, no new responsibility. Every city—not every city, but practically every city—provides a general hospital in which free medical care is provided for those unable to pay for it, and the general interpretation of those "unable to pay for it" is fairly liberal, while efforts are made to collect money from those who can afford to pay. Many people who can afford to pay a little do not pay anything.

The general system is loosely administered. There are no strict tests, as a rule, of exactly how much income a man must have before he gets that care from medical service of this nature. Emergency service has to be given often without determining in advance what a man's income may be—for example, if he is brought in from an automobile accident.

In general, that is the system enforced today. In general, the people of the rank above that of those who are unable to pay, pay for their own doctors.

There is a field, of course, of people who can pay, who are able to pay from their incomes, for medical care, but are likely to be hit one year by a heavy burden and then have no burden for several years, so that those people are better off if we can stimulate the provision of health insurance if they want health insurance.

The general purpose of this program, as I say, is to enable the States to expand that service.

We provide that the program may, at the option of the State, provide medical-care service in one or more of the following: institutions, homes, or a physician's office. The States may decide how they want to reach them—what is the best method in their opinion to reach people unable to pay for medical service.

Such program may also provide for the furnishing of such service to families by means of payments, in the nature of premiums or partial premiums or reimbursement of expenses or otherwise by the State, to any voluntary health, medical, or hospital insurance fund, or other fund, operated not for profit.

The general theory of that grows out of the present growth of voluntary insurance, health insurance funds.

Last fall, when I was out in Michigan, I went through the whole Michigan office which is perhaps more complete than any other in which there is a complete voluntary insurance service for sickness—I think for everything except services in the home—at a very reasonable figure.

We figured in this bill that if a State desired to stimulate that kind of service, it could; it could go to that service and say, "Here, instead of our providing free care—we do not happen to have a State hospital or city hospital in this place—we will pay the insurance; we will pay the insurance fund to provide services. We will pay the insurance premiums, so to speak, for those who are unable to pay those premiums themselves."

That would give these funds a backlog of work and a volume of work which would enable them to make progress and come to offer that service to many other people in the district who are able to pay for the service but desire to take it out in the form of insurance, and to protect themselves against any extraordinary medical catastrophes or calamities in their families.

I think that the provision we have today for insurance—the Michigan fund—is paid by the Veterans' Administration to take care of the veterans and perform the services of the United States Government as to the veterans. For that purpose, they employ this fund. That does give that fund a considerable volume of business and helps them get ahead and make progress.

The funds are developing rapidly, and as far as health insurance is desirable for those who are able to pay for it, it seems to me we should do everything to bring that about through voluntary insurance funds, and leave the principle voluntary.

If a man does not want to pay hospital insurance, if he is willing to take a chance, if he thinks that he himself is particularly healthy and has no particular reason to expect to require a doctor—I think I would have lost a lot of money if I had taken out health insurance myself in my early days—he does not have to do it.

I do not think that compulsory insurance is insurance at all; it is taxation. It is not a principle of insurance if it once becomes compulsory.

If you want the insurance principles applied, it seems to me you must do it through voluntary insurance funds.

In general, this system will permit the continuation of the present form of the medical profession, the present organization of the medical profession. It will enable them to build up, to expand those services.

Already the medical profession furnishes many free services; but free service rendered haphazardly is not systematic and undoubtedly misses many people who ought to get it. This will enable that service to be more completely extended but will maintain the independence of the medical profession—every doctor an independent unit as every lawyer today is an independent unit operating for himself.

It seems to me the maintenance of that freedom is a very essential part of the maintenance of our system of free enterprise.

I want to emphasize the fact, of course, that there are two questions involved in comparing this proposed approach with the approach of compulsory national health insurance.

One is that this proposal is based on State and local aid. The State submits the plan. The whole thing is administered, the distribution of aid is administered by State and local officials in accordance with the State law, either by State officials or by local officials.

The responsibility is primarily on the State. All the Federal Government does is check up to see that the money is given and that the purpose and plan that the State submitted was in accordance with the statute, was approved by the Federal Director of Health and was actually being carried out.

Senator Smith. I take it, Senator Taft, that the theory of your bill is that you are glad to encourage different approaches by the States and experiments by them in development of the best possible means.

You are not asking for uniformity all through—uniformity in the different States?

Senator Taft. I think that is a very important point.

In the first place, this bill proceeds on the theory that what we are interested in is seeing that everybody gets medical care. In other words, we are simply proposing to expand the present system and the present theory of furnishing free medical care to those who are not able to pay for it, under the present organization of the medical profession, as compared to a plan of compulsory health insurance in which everybody pays in, where the medical service is, in effect, in the last analysis, rendered by the State and the doctors are all employees of the State.

While the form is a little different, you get very much the same condition finally that you have today in which all teachers in the educational field are employed by the State.

This plan is based on the theory of keeping the medical profession an independent profession and not socializing the medical care, not giving everybody medical care.

The difference between giving 20 percent of the people free medical care, if you please, or 25 percent, those who are unable to pay for it themselves, and giving it to 100 percent of the people, is the difference between socialization and the maintenance of this particular system on a principle of freedom of action and freedom of enterprise.

The second difference, however, is even greater because this is based on State administration whereas the plans so far presented for compulsory health insurance, as far as this Congress is concerned, are a nationalization; in other words, not only is it proposed to socialize the distribution of medicine, but it is to be socialized in the care of a Federal bureau to serve the entire United States under a uniform system and make the doctors, as I say, in the end the servants or the employees of the Federal Government.

Even in the teaching profession, which is socialized as far as the elementary schools are concerned, the employees are employees of the State and local governments. They are not employees of the Federal Government.

And so, the present proposals or all the proposals I have seen, at least, for compulsory health insurance in bills presented to Congress, contemplate a nationalization of this thing, at the same time that the profession is socialized.

I do not think any of those plans really would meet with the approval of the American people if they understood what they were.

In all of these affairs, I am in favor of taking the abuses that you find and trying to meet those abuses and I believe that is fully taken care of by the provision of free medical care of all of those unable to pay for it, which, as I say, is interpreted in rather liberal ways, and as a result is not a difficult thing to find out nowadays because practically everybody has to make out income-tax returns.

You know their income and you know their wages. You can prescribe very easily a standard if you want to, and in any event, it is not a field in which there has been very tight control.

I think you would find a fairly liberal interpretation of who can pay for things and who cannot afford to pay. I know in Cincinnati we have for years taken care of people at the general hospital. The collections have been rather inadequate. I think probably people could have afforded to pay more than they did pay.

But, the general theory of the bill is that the people of the United States shall pay for medical care as they pay for food, as they pay for their clothing, as they pay for all the other necessities of life. And, there seems to be no particular difference, that I can see, in medical care. The moment you abandon that assumption and say, "Here is something that the state is going to give you," you are going on toward the gradual provision of the state for all of the necessities of life.

I think if we are going to maintain our system in this country, we have to base it on the theory that we are going to ask people who can pay for things to pay for them themselves, and only extend Government aid to those who are unable to pay.

Now, on the question of extending that aid and of the need of some system, and of the place of the Federal Government, I felt myself that under our system—I do not care how well it works or how little unemployment there is—there are a large number of people, either through their own misfortune or through their own inability or perhaps through their own unwillingness to work—who are unable to get a basic income sufficient to live decently.

That may be because they are doing a character of work which economically just is not worth more money than they get for it, so they do not get enough.

I think that is a necessary accompaniment of any system of freedom of economic enterprise, and one of its defects, and I believe that our people feel that it is a defect and that our people feel that this country, the productive ability of this country, is so great that it can afford to see that we abolish hardship and poverty in the United States, that we put a floor under essential services.

I think that this is demanded by the humanitarian instincts of the American people.

You can find some economists who go so far in laissez faire theory that they are prepared to say, "Well, let the devil take the hindmost; let the people who can't eat, starve. They are the least efficient anyway." But, I never saw anybody willing to carry that theory through to the logic of his conclusions, and if he did, I am sure the American people would not stand for it.

You do have a little danger there that if you begin on this floor you tend to infringe somewhat on the general principle of the people getting such rewards as they deserve. You have to be careful that the floor does not get too high, that you do not begin to support people to a point at which they will not work, themselves, as hard as they should work.

Nevertheless, I believe that the people of this country are in favor of a floor under essential services. And, if you so provide, the expense of such a system—and I say it is possible in this country perhaps, where it has never been possible in any other country because of the great wealth of the country—when you come to try to tap that wealth, the States' taxation powers are found to be considerably limited, and that is where the need for Federal assistance comes in.

The States cannot expand their taxation systems very rapidly. They are already occupied by very definite obligations of the State and local governments.

Health in the State and local governments has always been a kind of fifth wheel, that came in after education, that came in after the basic services of government, and, of course, that came in after the other essential city services. It is my experience that it is always tagging along at the end of most local and State budgets.

Therefore, the health field particularly indicates that there is more reason to feel that Federal aid is necessary in order that the States may have enough money to meet this new kind of obligation or this new conception rather of an old obligation because we always have recognized the general principle of preventing extreme hardship and poverty or taking care of it in some way.

I think in this field, it is necessary that we have some Federal aid. However, if we are going to maintain our State and local systems it must be by leaving complete administration to the State.

If we are going to stay within a reasonable burden of taxation, it is going to have to be confined to those who cannot pay for it.

If we are going to maintain freedom of enterprise, it is going to have to not extend to 100 percent of the people furnishing them free medical care which they are perfectly able to pay for themselves.

That is the general theory of this bill. From time to time, I hope I may be able to sit with the committee, once we get through with the conference on the labor bill. I will leave the other features of the bill to be discussed at that time.

Senator SMITH. Senator Taft, have you a few minutes for questions, or do you have to go to your meeting right away?

Senator TAFT. Go ahead. I can be late to my meeting.

Senator DONNELL. I would like to ask the Senator a very few questions if I may.

Senator Taft, on page 18 there is a provision that any State desiring to take advantage of the title may submit a State plan and that the plan shall set forth among other things, a State-wide program to which you have referred.

Now, beginning at line 16 on page 18, it is stated that such program may also provide for the furnishing of such services to such families and individuals, by means of payments, in the nature of premiums or partial premiums or reimbursement of expenses or otherwise by the State, to any voluntary health, medical, or hospital insurance fund, or other fund, operated not for profit, et cetera.

It has been suggested in the statement which was made by the Senator from Montana this morning that the people of this country do not desire to become recipients of charity, and that this bill has in mind a matter of the distribution of charity, of alms, I take it he has in mind.

Now, as I read this portion of the bill to which I have referred, it is distinctly contemplated that the State program may, at least, include provisions for a voluntary health, medical, or hospital insurance fund, as distinguished from the mere distribution of charity.

Is that not correct?

Senator TAFT. Well, yes; it would amount to about the same thing, however. We will say there is a city which has no general hospital and has no particular medical care—a small city that is behind in some way.

In that particular case, you could set up or require the city to set up a hospital and go into the business of providing free medical care with doctors and so forth. It might be easier—you may have a private hospital there—for you to contract with a private hospital.

But, it might be easier, if one of these funds is starting or has started, just to say, "Now, here we figure there are a thousand cases in this town that fall within this general obligation to help, and we will pay the premiums; we will pay a thousand premiums to you for those people. You furnish them service just as you do people who pay directly who, themselves, pay their own premiums, people in the better walks of life."

The theory is that the Federal Government is interested only in providing a floor under medical service. That is my general theory on all of these bills—on housing, on whatever other assistance that we give. We have that condition now with the old age assistance as distinguished from the insurance fund.

So, it is clearly a question of giving to those who are unable to pay for it. That is not a question of charity. I mean the principle is recognized in every field. It is done in every community today.

It is done right here in the District of Columbia with reference to dental care. Children are all inspected free, as this provides. Their teeth are inspected free, and then those who are unable to pay, whose principal certifies they are unable to pay for dental care, get the dental care free. If the principal will not certify, they have to pay for it themselves.

There is no question. I hear no complaints. The system works perfectly as far as I know in the District. It is used as a model in extending dental care to children in other parts of the country.

Senator SMITH. You contemplate flexibility?

Senator TAFT. This whole business of a means test is just a bugaboo. It has been our custom, it has been the practice, and it is the practice now in every State in the Union, to have a means test, if you want to call it that—that is, to give people free services when they cannot get them otherwise, when they are unable to pay for them.

It is certainly true of public housing programs. It has been from the beginning. There is not the slightest implication of making people paupers. I do not know of any such results of living in a public housing project.

I just think that it is a bugaboo, and my whole principle, the only reason for Federal aid, in my opinion, in a field in which the States have complete jurisdiction and primary responsibility is that the States are not able to provide the necessary care for those at the bottom of the economic ladder.

Senator DONNELL. May I ask you, Senator—the point has been made that this bill provides for local State administration of the different programs, and the argument may be made that a general Federal administration of a Federal system would be productive of more efficiency, rather than leaving it to each State to work out a separate plan.

What is your view as to the relative merits of a national administration of a uniform plan as distinguished from the administration by local States of their respective plans?

Senator TAFT. Well, you probably know as much about it as I do.

My general feeling is that if you leave it to the States in this way, you may have a few States that fall down and present a worse picture than a national picture but that, on the whole, when you have a national system, it is a tremendous system. It becomes bureaucratized. It falls into a lot of faults and when they occur, they occur all over the United States.

We had this same question exactly in the WPA. The State relief might have been inefficient in some States and in some States it was going very much better, in my opinion, than it ever did after WPA got going. WPA was the imposition of a Federal relief system, if you please, for those unable to obtain work throughout the Nation, and before you got through, it developed so many faults of every sort, political faults, administrative faults, the system did not fit particular States.

Whenever you get a national system and try to run it from Washington, you run it perhaps all right for the fellows who are running it; one may know something about the State he comes from and he will put in a system, and then you find it does not work in 40 other States; it is not elastic. The Federal system is not elastic. It is too big. It gives no room for experimentation in all sorts of different fields.

Under this system, one State can try health insurance if it wants to. That State can do anything it likes. There are 48 States. It is a very experimental field in which there is no consensus of opinion of what the very best method is, whereas a Federal system attempts to impose one arbitrary stiff system on the entire United States.

Senator DONNELL. Is there any prohibition in this bill, Senator, against the use of Federal funds for compulsory insurance in a given State, if that particular State decides to use it?

Senator TAFT. I rather think it only provides for the voluntary in the present form.

Senator SMITH. It says, "or other fund" which might be construed to mean that if you wanted to——

Senator TAFT (interposing). No; I think the word "voluntary" covers the whole works, as intended by the authors.

It was not intended to give aid to a State fund, but that certainly is something on which I have no very strong view and it is something the committee should decide.

Senator DONNELL. You think the committee should consider that?

Senator TAFT. If the State has a fund. In my opinion, the principle of the bill is that the Federal funds shall go to those at the bottom of the scale, so to speak, who, in effect, are charitable patients under any system of compulsory health insurance. They do not pay anything in. They earn nothing so they pay nothing in and they get free medical service.

It ought, in my opinion, to be devoted to that end of the job. I think it would require a considerable outlay to try to give Federal aid to people who are able to pay for the things themselves, and are taxed for it.

That question I have not considered very thoroughly. We simply saw the difficulty when we drew the bill and we left it out. We did not put in any aid for a compulsory State insurance fund.

Senator DONNELL. You think that is one that the subcommittee should consider?

Senator TAFT. Of course, a State desiring to do that could and does often separate the indigents, medically indigent anyway, from the others.

As I understand it, even with a compulsory health insurance, you may find a kind of indigent and maybe it should be worked out that this money should go to that.

Senator DONNELL. I would like to ask also——

Senator TAFT. I mean we have no desire to discourage a State from going ahead with a compulsory health insurance fund if it wants to, but I do not believe we ought to give Federal money to other than those people unable to pay for it themselves.

Senator DONNELL. I notice on page 21, lines 9 to 11; it is stated that it is intended that the State shall devise in each case the methods by which this end is attained.

I am wondering if that sentence has been particularly considered by Senator Taft.

Senator TAFT. Well, it is one of those statements that is not law. It is only to call attention to the fact that we just wanted to restrain the director from coming in and telling the States they had to do it in a particular way.

I think you can probably leave the sentence out and not change the theory of the bill, but this is just to emphasize it a little more.

We intended that the methods by which this service is to be attained, whether through the voluntary fund or through direct aid to hospital service in the homes or in some other way, or in clinics, should be left to the States as widely as possible, as long as the ultimate aim of reaching everybody who is unable to pay for medical care is attained.

That is the reason for that.

Of course that is the theory of the bill. This sentence, I think, was just emphasis, to emphasize that a little more.

Senator DONNELL. I appreciate that the Senator has to go to another conference but there is one other question I would like to ask him if he feels that he has the time.

That is this: On page 3 is the creation of the National Health Agency. I think there is pending another bill—S. 140 as I recall the number—providing for the creation of a Cabinet department relative to welfare matters.

I am wondering if the Senator thinks there is any conflict or inconsistency between S. 140 of which I think he is one of the sponsors or perhaps the sole one, and this provision about the National Health Agency.

Senator TAFT. There is an inconsistency that has to be worked out. I do not think there is any inconsistency of having a department compared to having an agency.

Under this National Health Agency, the health administrator reports directly to the President of the United States. Under the other bill, there is a Department of Health, Welfare, and Education and a Secretary of Health, Welfare, and Education. Under him is an Undersecretary for Health, who would head, in effect, a health agency, one of the three divisions of that department, which would be a health agency.

The chief difference would be that that man, that Undersecretary of Health would report to the Cabinet officer instead of reporting directly to the President.

Now, there are other differences within the actual set-up and there will be a good deal of discussion, and, I believe, some modification is necessary here.

Whatever is finally agreed upon, I think should be written either into this bill, if this bill goes through, or if the department bill goes through, should be written into the department bill. That is in another committee.

There are inconsistencies which will be discussed, but I see nothing that cannot easily be reconciled, except for one difference—except here, this contemplates a man reporting direct to the President, which is necessary if you do not have a department. But if you do have a department, I see no particular reason why the National Health Agency should not be one of the three branches of that department.

In that bill, I objected very strongly to putting any undersecretary between the Cabinet officer and the head of the Health Agency. And, it does not have any such intermediate officer. I felt that health is entitled to be considered, not to be bossed, so to speak, by welfare, and I was afraid that an undersecretary in this department, a general undersecretary, would likely be a welfare man without particular responsibility.

I do not think the health people should object to a health agency reporting direct to a Cabinet officer, a man of Cabinet rank because I see no reason why such a man would not feel equal obligation to take care of health as he does of welfare.

Now, there is that substantial difference. If we have a Department of Health, Welfare, and Security, this health agency will have to report to the Cabinet officer.

Now, there are a lot of others which you will probably hear a good deal about at these hearings, as to whether this is the right set-up for a health agency inside the health agency, and I certainly hope there is the conviction and desire to meet whatever we determine is the best set-up for that agency.

Senator SMITH. Senator Pepper, did you have a question to ask?

Senator PEPPFR. Just two or three.

What is the matching principle provided in your bill, Senator Taft?

Senator TAFT. Well, let us see. I had a matching principle and then I do not know whether we have any now.

I did not——

Senator DONNELL. Page 19, Senator, is it not? Line 17 and following? The financial contributions to be made——

Senator TAFT. Should be at least equal to the amounts contributed for similar purposes in the year 1946, and at least equal to the Federal aid payable under this title.

Senator PEPPER. 50–50?

Senator TAFT. 50–50.

I do not think the States will have any difficulty doing that at all because, as a matter of fact, this Federal aid is not likely to amount in most States to anything like 50 percent of the total amount of money spent on health so I was not fearful particularly.

There might be some States where that 50 percent would require greater State contribution than they now make to health but when you add up the States and all the localities, all the free medical care given everywhere, I think you will find the State expenditures today—we provided only $200,000,000—I think the State expenditures run a billion and a half anyway.

Senator PEPPER. But, the 50–50 matching principle does ignore ability to pay, does it not?

Senator TAFT. Yes, it does, because we felt, as I say, that it was a figure that would be pretty easy for even the poorer States to comply with.

Senator PEPPER. 50–50?

Senator TAFT. We give those States more money under the allocation principle. The poorer States get two or three times as much in proportion as the wealthier States.

If it develops in our plan that any State is seriously handicapped by the 50–50, I think we might consider a modification of it.

Senator SMITH. You figure on crediting a State with whatever it is spending at the present time against that 50–50 matching requirement?

Senator TAFT. Yes; whatever——

Senator SMITH. It is not new money?

Senator TAFT. Whatever the State is spending, whatever the localities, the cities and counties are spending on health.

Senator Pepper. Is it fair—I am not quite clear as to what the facts are—is it fair to say it is substantially a 50–50 matching principle or that it is not?

Senator Taft. Yes, it is 50–50, except that most States would be supplying probably 79 or 80 percent rather than 50 percent.

Whether you get any poor State which is going to be handicapped—take the State of Alabama, with $5,000,000, the State of Ohio, $8,000,000. It is spending certainly far more than $8,000,000 today on health. The city of Cincinnati alone, I think, is spending two and a half to three million. Alabama, $5,000,000..

I think we should look into the question of whether they can meet that 50–50.

The question of what the State puts up now in cash has not been developed and we probably should develop it before we get through and be sure that this 50–50 rule is not going to seriously handicap any State.

Florida, $4,079,000, I do not know what you spend, but you probably spend $4,000,000 today in the free hospitals that you have and the other public health services, and all sorts of things.

Senator Pepper. I am afraid that the poorer States would be under a handicap to meet that matching principle.

Senator Taft. Well, we can find that out.

Senator Pepper. Yes.

Now, Senator, how is the medical personnel paid for the services it renders under this bill?

Senator Taft. That is entirely up to the States. Many States have public health doctors, you know, and some States have been paying by State and local funds, supplemented by Federal money.

Senator Pepper. But, under the bill, the doctors are paid for the services they render, out of either State or Federal funds, or both?

Senator Taft. That is right.

Senator Pepper. And, what made me curious about that was——

Senator Taft. Federal funds are really added to the State money, whatever it is. Under the State plan, however they propose to do it.

Senator Pepper. But, what schedule of fees will they be governed by?

Senator Taft. That would be primarily up to the States.

Senator Pepper. Well, what made me ask that question——

Senator Taft. The chances are they would, in most cases, well I would not want to say, because they have different systems. Sometimes they have doctors on salaries—they do in some places—and in other places they would be on some system of fixed fees, I suppose.

Senator Pepper. Would the Senator suppose a public health service or the State agency or the agency representing the public authority under this bill would pay any fees that any doctor might charge, or do you suppose that they might have some schedule of fees?

Senator Taft. No State would do that. The State would have to have a schedule. If they get these public funds, they have to set up schedules.

The Michigan fund, for instance, sets a schedule of fees for doctors, and the State would presumably only contract with such a fund to provide free medical care if that were the way they were handling their job—if that schedule met with the approval of the State.

Senator PEPPER. Well, what made me curious about that was what I understood to be the arrangement also under the Wagner-Murray-Dingell bill, and certainly as modified as introduced yesterday, that same principle would be observed, and you seem to characterize the latter as socialized medicine or regimentation of the profession, and yet where public funds pay the doctor, and there was an agreed schedule of fees, and where doctors came in or did not come in the system under your bill, I do not suppose you find any objection about that.

Senator TAFT. The difference is that you reach 20 percent of the people instead of 100 percent. You reach 20 percent. I mean for years we have always recognized the State's obligation to provide free care to the poor, we will say, to the 20 percent at the bottom of the scale.

Senator PEPPER. But, the principle——

Senator TAFT. That is not socialism. The moment, however, that you proceed to provide Government free care or free service, or free food or anything else to people who are perfectly able to pay for it themselves, you socialize that particular field. I mean it is not a crime to socialize a field. We socialized, as I say, the primary education. It has been socialized in this country for a hundred years. I do not object to it.

Only I object to the extension of the system because ultimately, if you go too far, you turn the whole thing into socialism.

Senator PEPPER. Why do you say it is a gift to the people when they are participants in an insurance fund and paying a percentage of their wages?

Senator TAFT. Because that aid goes to people who do not pay. They pay——

Senator PEPPER. On the contrary——

Senator TAFT. They pay 3 percent of something and they get medical aid 10 times what they pay, if they pay anything. It may be they are not working at all; then they do not pay anything.

Senator PEPPER. Well, under, let us call it the National Health Insurance Act, there is recognized the very class of people you provide for in your bill; namely, the people not able to pay the insurance payments, that are periodically required, and it is provided in the bill that the State may pay the premium.

As you say, they may pay the premiums in the voluntary association that you contemplate. The difference is, except for the people who cannot, as found by the local agency, pay the premiums, everybody else pays.

If he is an employee, he pays, we will say 3 percent of his wages up to $300 a month, and the employer, if he is employed, puts up the same amount.

If he is self-employed, he pays whatever——

Senator TAFT. Senator, that is a tax; that is no fee; and it is not a tax for his medical care. He may get 100 times that. He may be a man who, if he went to a private insurance fund, might pay four times that much because he had four or five children and a situation which was much more expensive.

Compulsory insurance is not insurance; it is a tax. All of the people are taxed. For what? To provide 4 percent that is suggested, as I saw it—I have not followed it—4 percent of the pay roll which would bring in about 4 billions of dollars into Washington, and then that money is used to pay all the doctors in the United States to render free medical service to all the people in the United States.

It is a tax. It is a tax just as much as a tax for education is a tax, and just because you base it on a pay roll does not make it less a tax nor does it bring it into any closer relation to the value of the medical service rendered.

What you are doing is taxing all the people to render free medical care to those who require medical care.

Senator Pepper. Except for the compulsory aspects of it, what is the difference between that insurance principle and the insurance principle of the voluntary insurance?

Senator Taft. The voluntary insurance is voluntary insurance. You do not have to take it unless you want to.

Senator Pepper. It is insurance, however.

Senator Taft. That is really insurance. But compulsory insurance is not insurance. Compulsory insurance is a tax.

Senator Pepper. But, in one case they pay the premiums and it is based on actuarial experience and the number of people to be covered——

Senator Taft. No; it is not based on any actuarial experience for those people. They pay in relation to their pay roll. Here is a fellow that needs just as much medical care as another fellow and he pays $100—or say, $10—and this fellow pays $100——

Senator Pepper. What I mean is——

Senator Taft. Although he does not require any more medical service. It is a tax.

Whereas, if there was voluntary insurance, they would each pay the same.

Senator Pepper. What I mean is, we all pay into the voluntary insurance fund and one man may get 10 times as much care as the other.

Senator Taft. That is entirely a different thing.

Senator Pepper. The whole fund, if it is adequate to meet all the expenses incurred, that is typical of the insurance principal.

Now on the other——

Senator Taft. No; but the people pay on the basis of what their actuarial chances are for the service they require.

Under compulsory insurance funds, you pay in reference to what they receive in wages. That is a tax that has no reference to insurance at all.

Senator Pepper. That is——

Senator Taft. Because this fellow pays 10 times as much for what he is getting, the services he is buying, and this fellow pays one-tenth of what he is buying. It is a tax.

Compulsory insurance is just a name. It is not insurance in any sense. It is a tax to build up a fund to pay for free medical care to all the people in the United States.

Senator Pepper. Well, it is a little strange to say a man is getting something for nothing when he is paying part of his wages every month to share in the benefits of it.

Senator TAFT. If he has any wages. He gets the benefits anyway. If they are low wages, he is getting it at one-tenth of its value, which is a tax principle.

If you want to equalize, of course, the way you want to do it is by taxation—take away from the rich and pay it to the poor. But, it has to be recognized that is taxation. That is not insurance.

Senator PEPPER. On the contrary, that offers a method by which people contribute to their own medical care, whereas under the system you impose, a man either gets charity or he gets nothing.

Senator TAFT. No, no. It provides and we provide that a man shall pay what he can. That is customary here right today in the District of Columbia. A man comes in——

Senator PEPPER. That is charity. That is the system we have now. Charity hospitals.

Senator TAFT. A man comes in—no, no; you say it is either one or the other. I say it is not either one or the other. A man comes in and has to have an operation for appendicitis. They ask him, "What can you pay? The regular charge is $100."

Well, he cannot pay $100.

"Can you pay $50?"

"Maybe I will pay $50 spread over 10 weeks."

"All right, he gets it for $50." I mean there is no arbitrary division. It may be a partial payment or not.

Now, that is up to the State and the localities to determine how they do it.

Senator PEPPER. Now, what will be the standard of need which will be applied?

Senator TAFT. That will be up to each State, subject to some over-all control, I suppose, of the plan submitted. There will have to be something within reason for the Federal Government to approve.

Senator PEPPER. You certainly do not mean under your $200,000,000 to accomplish the declaration of purpose and policy carried on page 2:

> That it is the policy of the United States to aid the States through consultative services and grants-in-aid to make available medical, hospital, dental and public health services to every individual regardless of race or economic status.

You do not expect to accomplish that with a $200,000,000 appropriation?

Senator TAFT. I would think $5,400,000 added to the present money spent in Alabama on health, for instance, would come fairly close to providing such service. It might not be as high as you would like to have it.

This would have to be a gradual thing. We might ultimately have to put up more than $200,000,000. Two hundred million dollars is a start. I think probably it will be more expensive in the end to do that; yes.

Senator PEPPER. Senator, do you not recognize that at the present time, the people who suffer most are what we call the middle class? If a person is an actual charity case and is going to accept charity, he can get charity or medical care from a doctor or hospital from nearly anywhere in the country.

But, it is the white-collar worker, or the person earning a fairly decent income who is not disposed to accept charity and has to pay too much to get voluntary insurance under the present system, who constitute the class today that is suffering.

Your system does nothing to help that class.

Senator TAFT. It stimulates the provision of health insurance which is rapidly spreading throughout the United States. Your own assumption is that this middle class can pay that insurance, and all we are doing is trying to stimulate the development of that insurance.

I think it would be very unfortunate to get the Federal Government interested unless that insurance fails to become available. It is available today in a great many places.

Senator PEPPER. Two and a half percent are covered by comprehensive insurance plans.

Senator TAFT. Maybe they do not want it.

Senator PEPPER. Most of them cannot pay for it.

Senator TAFT. Oh, yes; most people can pay for health insurance if they want to.

Senator PEPPER. It is easy to say that from your point of view or mine, maybe.

Senator TAFT. No; I went through the Michigan system and studied the Michigan charges. I do not have the charge here for hospital insurance and for medical insurance. It is a figure which comes to about, as I remember it, the whole thing for a family of five or six, about $7 a month—hospital insurance, birth of children, tonsillectomies, the whole field of medical insurance at $7 a month.

That is not too big an item for the people above the 25 percent of what you might call indigents.

It can be provided on a voluntary basis and is rapidly being provided if people want it.

You also have this thing: If you do not have it, you have many agencies today where, if a family does have a catastrophic illness in 1 year, they can borrow the money at very reasonable rates and spread the payments over the next 3 or 4 years, which is the same principle of spreading that would be involved in a prior taking out of voluntary health insurance.

Senator PEPPER. You take the case of a man, say, earning $4,000 or $5,000 a year, with a family, a wife and four children. If that man has an opportunity to pay every month a certain percent of his income to a fund and then can claim his medical care for himself——

Senator TAFT. How much was that?

Senator PEPPER. Himself and family, say, a man making $4,000 or $5,000 a year—with the expenses that are demanded of a family today, I say if that man can pay a percentage of his income every month into a fund and walk up like an American and get medical care and hospital care and clinical care and diagnostic care and that sort of thing for his family, then he feels that he has the right to have it. He does not have to go in and ask for charity from the State or from the Federal Government.

That is the class of people who want an opportunity to get cheap insurance, and that is what the Murray bill affords, and that is the class that your bill does nothing for except to offer them the hope of charity if they are willing to accept it.

Senator TAFT. Just a moment. Here is a $5,000 man. Under your bill, he will pay $200 a year. In Michigan, he can go to the insurance fund and get the same thing for $84 a year. As far as the $5,000 man is concerned, you are taxing him to support the $2,000 man under your plan.

Senator PEPPER. The $2,000 man is——

Senator TAFT. It is going to cost him twice as much under your bill as it would to take voluntary health insurance under the Michigan plan.

Senator PEPPER. Well, I challenge the fact that the Michigan plan affords the completeness of coverage which would be afforded by the Murray bill at the present time.

Senator TAFT. That is a question.

Senator PEPPER. Not only that, but the small man would pay only a percentage of his income just like the man of larger income, and nobody pays on that part of his income in excess of $3,600. So, you would have to cut that down under the Murray bill from $5,000 to $3,600.

Senator TAFT. I have not read the bill, so I cannot say. So that makes it $144 compared to $84 in Michigan under the voluntary health insurance plan.

Senator PEPPER. Your bill is simply the equivalent of a further appropriation of Federal funds on the grants-in-aid for the States and, of course, every dollar that we make available is that much of good. But, to hold out your plan—and I commend any dollar, you know I would like to vote for as much as could be made available to help the people of this country in all these fields—but to hold that out as hope for adequate care in the whole medical field for the masses of American people, I cannot see it as anything but delusion.

Senator TAFT. The additional tax of $4.000,000,000 to the people is also a very discouraging thing to the future of the country.

Senator PEPPER. That is one thing.

Senator TAFT. That is, from people who do not want to pay it. It takes from this particular family you are talking about $144 instead of $84 for the same thing. It imposes a tremendous Federal control and takes all freedom away from the medical profession, and I think will be a serious deterrent to the development of medicine which has been outstanding in this country.

Senator DONNELL. Mr. Chairman, if I may——

Senator PEPPER. Just one more, and I will quit.

Senator DONNELL. Might I interrupt for just one moment on this point?

Senator PEPPER. Surely.

Senator DONNELL. Senator, you referred to compulsory health insurance as a tax. I would like to ask the Senator if this is not true that in the testimony before the Committee on Education and Labor last year or the year before, was it not brought out very clearly that the expense of the compulsory insurance plan would not be by any means carried solely by these pay roll contributions, that there would be a deficit in addition to that which it was clearly contemplated would be taken out of the general public treasury, thus emphasizing the Senator's point that the compulsory, Nation-wide insurance plan is, in effect, a taxation plan?

Senator TAFT. I think it is true. I am not prepared to make any flat statements about what this is going to cost because I do not think there ever was evidence of what the national administration and distribution of medical care would cost. I suppose it could cost less or more, according to what you give. As I understand it, this contemplates, while it is not a tax bill, a 4-percent tax. Last year, I had the impression it was 3 percent plus 1 percent to come out of the Federal treasury.

But, what health will actually cost is a matter of dispute and I am not in a position to take either side. I don't know.

Senator DONNELL. The point I was making is that the excess over and above the contributions from pay rolls——

Senator TAFT. Will be paid out of the Treasury.

Senator DONNELL. Paid out of the Public Treasury.

Senator TAFT. Yes.

Senator DONNELL. Which, in turn, secures the funds from taxation.

Senator TAFT. That is right.

Our plan, in short, proposes to help the States do their job more completely by taking care of the people who are unable to pay for medical care, and also stimulates the States to encourage the development of voluntary health insurance funds for the group above the bottom group which is directly covered by the Government aid.

Senator PEPPER. But, Senator——

Senator TAFT. We claim that that system is a development and an improvement of our present system instead of a scuttling of the entire present system and setting up a national dispensation of all health service.

Senator PEPPER. But, Senator, yours is exclusively a tax plan—all the money you disburse.

Senator TAFT. It is exclusively a tax plan but it applies, in effect to 20 or 25 percent whose freedom is thereby limited to some extent, but who, after all, are in such a low economic condition that they have to look to the State for some assistance and always have and our system has always recognized it.

We are not putting in any new principles. We are simply saying that this obligation to give free care to those unable to pay for it shall be more systematically and comprehensively carried out to eliminate extreme hardship and poverty in the United States. It is part of a general plan to eliminate extreme hardship and poverty in the United States.

Senator PEPPER. I know you stated, Senator, in the beginning that you had not had a chance to read the Murray bill yesterday.

Senator TAFT. I have not seen it. I saw the summary of it that Senator Murray put in the record.

Senator PEPPER. You have naturally addressed yourself to the bill as you understood it as introduced last year?

Senator TAFT. Yes.

Senator PEPPER. I did want to call attention at the beginning of the hearings so that other witnesses might have a chance to investigate the bill as it now is.

Senator TAFT. I do not understand, Senator, there is any change in the general theory of the tax on pay rolls to provide Federal funds, and the care to be distributed by the Federal agency which collects the $4,000,000,000 that comes in.

Senator PEPPER. The tax principle, Senator, is the same as it was last time, but there is a very significant change in the administrative procedure. That is, it is decentralized, and the States, just as they do under your bill, submit plans and while there is a Federal board, of a sort of generally coordinating character, nevertheless, a great deal—in fact, almost exclusive freedom—is left to the States to evolve their own plans and administrative procedures in the carrying out of the terms of the bill.

That, I just want to call to your attention.

Senator TAFT. That sounds like an improvement but I have not read it.

Senator SMITH. Senator Murray, do you have any questions?

Senator MURRAY. No.

Senator SMITH. We are very grateful for this presentation, Senator Taft. I hope you can be with us at all of our hearings.

Senator TAFT. After this week, I think I can get here.

Senator SMITH. Is Dr. E. J. McCormick here?

Dr. McCORMICK. Yes, sir.

Senator SMITH. Dr. McCormick, we would be glad to hear from you now.

Dr. McCORMICK. With your permission, I would like to suggest that Dr. Sensenich present his material first as it would be more in order.

Senator SMITH. I would be glad to hear Dr. Sensenich then.

There are two witnesses. I will advise the witnesses that it is now 10 minutes to 11, and we have a Senate session at 12 o'clock which we are required to attend under the Reorganization Act, so we have a little over an hour for the two witnesses.

Dr. Sensenich, will you be good enough before you give us your testimony to state for the record just what your background is and your qualifications as a witness?

Dr. SENSENICH. Yes, Mr. Chairman.

## STATEMENT OF DR. R. L. SENSENICH, CHAIRMAN OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. SENSENICH. I am a practicing physician in South Bend, Ind. I am here by reason of the office I hold as chairman of the board of trustees of the American Medical Association.

Senator SMITH. May I ask you where you live and where you practice?

Dr. SENSENICH. South Bend, Ind. I am in the practice of medicine full time.

Senator SMITH. I am always interested in doctors. My father was a physician and I was raised in a medical family, and I am very much interested in this whole subject.

Dr. SENSENICH. I knew that, Senator Smith, and I added "full time"—when I do not come down here. [Laughter.]

Senator SMITH. Will you go ahead, Doctor, and give us your statement?

Dr. SENSENICH. Senator Smith, if I may, I think perhaps we will save time if I read the statement. I may digress if I try to discuss it.

Senator SMITH. Now, Doctor, would you prefer to read your whole statement before we interrupt you or if we have questions, that we interrupt you?

Dr. SENSENICH. What is your preference? It is immaterial to me.

Senator SMITH. You are perfectly willing to be interrupted when we have a question?

Dr. SENSENICH. Yes.

Senator SMITH. All right, Doctor, go ahead.

Dr. SENSENICH. In the beginning of the statement, I set forth that the American Medical Association, as of record May 1, 1947, includes 132,659 physicians who are members of the county and State medical societies. The policies of the American Medical Association are determined by the house of delegates. The members of the house of delegates, numbering 175, are elected by the respective house of delegates of the individual States which, in turn are elected by the members of the county medical societies. The association, thus, is democratic in its organization and in its functions.

That is simply to make clear to the committee whom the association represents and the manner of the selection of its delegates and those who speak for it.

Senator SMITH. Am I correct in my understanding that every State in the Union is represented?

Dr. SENSENICH. Yes, sir.

Senator DONNELL. May I ask the doctor what proportion of the physicians of the Nation are members of the American Medical Association?

Dr. SENSENICH. Well, nearly all of them. There are about—I think about 150,000 doctors.

Now, there are some who have graduated and who have never followed the profession, and there are some in insurance offices, and many other lines. But, of the practicing group, I mean of the practicing physicians, this constitutes almost the entire body.

The American Medical Association has now completed 100 years of organized existence—I think we might well tell you how old we are and how long we have been interested in these problems—devoted to improving the standards of quality of medical service and broadening the distribution of the best medical care to all the people.

The association, throughout these years, has directed continuing study and experiment to improving methods of undergraduate education in medicine, the organization of opportunities for postgraduate study and the creation of facilities for the provision of the best medical care, including service to the indigent and those of low income.

The direction of these efforts throughout the whole field of study and improvement of standards and methods has been characterized by close contact and cooperation with the health activities of governmental agencies, Federal, State, and local; educational and research institutions, voluntary groups; and philanthropic health agencies. The association has also observed closely the standards and methods of distribution of medical care in other nations and has had the benefit of the experience and advice of unselfish investigators trained in the direction of health activities throughout the world.

These broad considerations of the problem of the best possible health for all of the people led the association to prepare a basic outline for continuing development and action. This is known as the National Health Program of the American Medical Association. The national health program is as follows:

1. Minimum standards of nutrition, housing, clothing and recreation are fundamental to good health.

2. Preventive medical services should be available to all and should be rendered through professionally competent health departments. Medical care to those unable to provide for themselves should be administered by local and private agencies with the aid of public funds when needed, preferably by a physician of the patient's choice.

3. Adequate prenatal and maternity care should be made available to all mothers. Public funds when needed should be administered by local and private agencies.

4. Every child should have proper attention, including scientific nutrition, immunization and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child health centers administered locally with support by tax funds whenever the need can be shown.

There, the point is that we plan to include in the development of a health program all the agencies, the voluntary agencies and every mechanism which can best serve the public.

5. Health and diagnostic centers and hospitals necessary to community needs are preferably supplied by local agencies. When such facilities are unavailable, aid may be provided by Federal funds under a plan similar to the provisions of the Hill-Burton bill.

6. Voluntary health insurance for hospitalization and medical care is approved, the principles of such insurance plans to be acceptable to the council on medical service and to authoritative bodies of State medical associations.

The reason for that was to prevent the entrance into the picture of insurance plans of a kind that were not sound and not consistent or in any way not fair or honest to the subscribers to such funds.

Senator Donnell. Mr. Chairman, may I ask the doctor what is the council on medical service?

Dr. Sensenich. The council on medical service is a council appointed by the American Medical Association of medical men all over the United States. They have a regional representation and that council cooperates closely, very closely, with the association of voluntary insurance plans, with the idea of determining what their methods are and their processes, and to see, again, that the patient is safely cared for and that there shall be no imposition or failure to provide the service that they contract to furnish.

Senator Donnell. Approximately how large a membership does the Council on medical service have?

Dr. Sensenich. Six, is it not? (Addressing Dr. McCormick.)

Dr. McCormick. No; it is nine, doctor, I think, including the officers.

Senator Donnell. They are selected by whom?

Dr. Sensenich. They are selected by the house of delegates of the American Medical Association.

Senator Donnell. Dr. McCormick will deal particularly with these insurance plans.

Dr. McCormick. It is 11, Doctor, including the officers of the association.

Dr. Sensenich. They are made up of representative men all over the United States.

7. Medical care, including hospitalization, to all veterans should be provided preferably by a physician of the veteran's choice, with payment through a plan agreed on between the State medical association and the Veterans' Administration.

8. Research for advancement of medical science, including a national science foundation, is endorsed.

Senator Smith. You are aware, Doctor, that the bill was passed yesterday that provided for a national science foundation?

Dr. Sensenich. Yes; I saw that.

Senator Smith. And, it has a provision for a division of medical research and also provides for a special division on cancer and heart disease. At least, if the bill is passed, we will move ahead in that field of scientific coordination.

Senator Donnell. You have very modestly omitted any reference to your participation in the passage of the bill for the National Science Foundation, Senator Smith.

It is only fair to Senator Smith to have the record show that he was the leader of the very strong and vigorous and effective group in the advocacy of the bill which was passed by the Senate by a very large majority yesterday afternoon.

Dr. Sensenich. We are very appreciative of the efforts of Senator Smith relative to medical research.

Senator Smith. I might say, Senator, that I was not seeking any bouquets when I mentioned the fact that the bill had been passed.

Dr. Sensenich. 9. Services rendered by volunteer philanthropic health agencies should be encouraged.

We feel that the matter of health is not an entire matter of legislation and compulsion but that after all the public must learn, first of all, the importance of health and how to obtain it and how to maintain it. It is just not accidental that the individual has good health in large proportion to how much thought he gives to it, barring, of course, inherited tendencies or disease over which he has no control.

That comes back to the matter of recreation and housing and the manner of living too.

10. Widespread education in the field of health, and the widest possible dissemination of information regarding the prevention of disease and its treatment, are necessary functions of all departments of public health, medical associations, and school authorities.

Might I say that the American Medical Association has for many years had liaison committees with all the big educational groups beginning with the National Education Association. We advise them in the matter of health in the schools and the importance of healthful recreation, participation in selected athletics.

That effort, as well as an effort to obtain high standards of health teaching in the schools, is of the greatest importance and we do endeavor to carry on with that.

Now, it must be recognized that each one of these 10 avenues of approach to the problems of health maintenance and necessary treatment reaches directly into each community in the country and directly or indirectly to every individual in that community. The complexity of a problem involving so many factors obviously cannot be adequately dealt with by a single social measure. Likewise, it must be admitted that each human being, as a mental and physical unit, is a more complex structure than any social system which could be devised. So much is dependent upon the individual, his capacity, his education, his training, his sense of values, and his opportunities, that any efforts made in his behalf must take into consideration all of these qualifications.

Senator **Smith**. Does that imply, Doctor, in your mind, that we will make more progress by decentralizing the operations of the State? Let them experiment in their own field with their own conditions rather than give them one over-all plan that may be blueprinted in Washington?

Dr. **Sensenich**. I think that is very important, Senator Smith.

Senator **Smith**. That is one of the issues before us—the best way to do it.

Dr. **Sensenich**. That is right, and to build up the individual and to recognize that after all each has his individual problems; it is not anything for which a prescription can be written at a high level that is going to adequately meet his needs and encourage him to do the things that he ought to do for health.

No social or legal measure can cover this field by any process of compulsion without in the end destroying the very qualities we seek to stimulate and develop in the individual.

Senator **Murray**. Doctor, right there——

Dr. **Sensenich**. Senator Murray?

Senator **Murray**. I notice by this language here, you express disapproval of any process of compulsion because it tends to destroy the individual's character.

Dr. **Sensenich**. Yes, Senator.

Senator **Murray**. Well, does not the bill which is before us now contemplate compulsory taxation for the purpose of carrying out this program?

Dr. **Sensenich**. For meeting the need, because, obviously you cannot insist upon the individual doing a thing for which he does not have sufficient finances.

But, it does exclude from the compulsion the individual, the average individual, who really is quite capable of taking care of himself with the mechanisms provided in voluntary plans, Senator Murray.

Senator **Murray**. Yet it does contemplate a wide compulsion in order to be able to carry out the program. It requires a compulsory taxation. It requires compulsory methods of handling the program.

There is no way in which the individual can secure this service unless he submits himself to the compulsory methods that will be laid down in carrying out the program. He will have to come in and go through lengthy examination and investigation of his means, and then he will have to comply with the methods which were set up for the purpose of securing this service.

He will not be able to walk into any hospital and get the particular service that he would like to have. He will have to take the kind of service that they would give him. He would be compelled to accept that kind of service.

Dr. **Sensenich**. Senator Murray, I think that the program provides that the premiums, for instance, in the voluntary insurance plans, may be paid from Government sources. Then he simply qualifies for that insurance and then he receives the same benefits as the other individual does who does not derive them from the same funds.

I am not deeply impressed, Senator Murray, by the matter of means. Everything the Government does is on a means test. Please let us be direct about that.

They determine how much tax we pay on the basis of our means. Old-age assistance—if I am earning more than 50 cents a day, I do not get assistance and even in the matter of old-age and survivors' insurance, it is surrounded by so many forfeitures that, again, it is a matter of taxation with a lot of frills, by which the individual must qualify—and that is not saying anything unkind about the plan.

It would cost much more, no doubt, if it were operated on any other basis but, nevertheless, that does apply.

Now, it is hoped and believed, Senator Murray, in the administration of this plan that it can be done without the offensive things which are brought before us from time to time as an objection to the bill, not assuming that every administrator of the provisions of this act is going to be unfair.

By taking that administration to the local community, Senator Murray, I think we will get away from a lot of the detached attitude that might of necessity come if your administration is from a much higher level.

Senator **Murray**. Of course, in life generally, means is an important factor.

Dr. **Sensenich**. Yes.

Senator **Murray**. And I suppose that when you say "means" you consider it in the light of the medical profession's consideration of means now in connection with the practice?

In other words, your fees are fixed on the basis of the means of the particular individual that you are going to give service to.

Dr. **Sensenich**. They are always modified for those who are unable to meet them without hardship.

And, I think, that is working out very well, Senator Murray, from the standpoint—well, just this morning I heard the statement made that there were such a large number of people in the middle group who were unable to obtain the medical service that they should have. After all, that is a generalization that no one can prove. I would rather look at the facts than that general statement for the reason that they are actually in good health and they do maintain good health and, therefore, regardless of what we may assume that they could or could not pay, they are receiving the service. I do not know of hardship in that direction.

Senator **Murray**. Under this bill, is it not contemplated that in States where they have a system of county hospitals and county physicians that people who are unable to pay anything have to go to those institutions for care and services?

Dr. **Sensenich**. That would be a matter of local administration.

Senator **Murray**. I say where they have them already set up and were carrying out that system, it is contemplated that they will probably continue that system? Of course they have the right to change it if they desire.

**Dr. Sensenich.** I see no reason to confine, Senator Murray, the administration of the act to the public facilities in the event that the individual is covered by insurance. He might be taken care of just the same as any other individual might have the same facilities at his command.

**Senator Murray.** But, the practice at the present time in those States where they have that system of county hospitals and county physicians is that the people who are unable to pay just go to those institutions. That is the system in a good many States.

**Dr. Sensenich.** In a good many States it is, but still, by and large, Senator Murray, you know most of the patients in hospitals, excluding the veterans' hospitals, that those of them are taken care of by voluntary associations of hospitals or church hospitals.

There are more areas that do have the better policies. I see no reason why an individual covered by an insurance policy, even though the premiums were paid by the Government, should be forced to go to a county hospital when others went to the voluntary hospital.

**Senator Murray.** But, the bill does contemplate in cases where an individual is unable to pay the full cost of his medical care and hospitalization, that he has a right to submit to a means test and if that means test develops that he is unable to pay the full amount of the charges, then he is entitled to receive the services as a matter of charity.

**Dr. Sensenich.** Well, yes; if you wish to call it charity.

**Senator Murray.** Well, you cannot pay it and the Government pays for it. It is charity.

**Dr. Sensenich.** Presuming, Senator Murray, we are not too unkind in the application of that word "charity" because it is no greater charity than the charity he receives when he is cared for under a compulsory plan and his money is distributed largely by people who pay out of proportion to that which they should pay in order to support the plan.

**Senator Murray.** But, still he is receiving services in that instance under a national program which he contributes to, that he pays for and he feels that he has made a legitimate contribution along with all the other citizens and that he is entitled under that kind of system, to come in without being regarded as a charity patient.

He pays for it. He comes in as an American citizen, just like every other citizen and gets his medical care and hospitalization at rates he can pay which are within his means.

**Dr. Sensenich.** Well, Senator Murray, he receives a service for which he does not pay—period. Because the system at no time has been supported upon the payments of the individuals who fall in the category that you describe.

**Senator Murray.** Well, the medical profession receives their full payment under it. They are not losing anything by the system. As I say, the full amount of the charge against that individual is paid to the doctor or to the hospital and the doctor does not have to consider that he is contributing anything. He is not giving any charity to that patient.

The patient is getting his care and service under a national program which is legitimate, which is recognized as a valid method of providing for uncertainties. It is an accepted system in the United States—the insurance system, which enables people to make contributions.

Some people do not contribute sufficient funds to make it possible for insurance companies to pay back the amount that they received frequently. The person who might be insured for a year and dies—he gets the full amount of the insurance for which he subscribed, although he had only contributed a very insignificant part of it.

So, that is not regarded as charity. That is regarded as a legitimate American system of providing for uncertainties and misfortunes that we cannot guard against.

Dr. SENSENICH. But, Senator Murray, there is where the mistake is made. It is definitely not similar to any other plan. I am not speaking in the interest of the physicians. I am not interested at the moment whether the physicians are paid or not.

Senator MURRAY. But, they do get paid, do they not?

Dr. SENSENICH. Yes; but that is not our point. That is not what we are here for. What we are here for is to appear in favor of some of the provisions of this bill, or of this bill as against a compulsory plan which definitely is socialization.

I am not interested in how the physician receives his money, but when you raise the point that charity is, in a rather unpleasant connotation of charity, that which comes to the individual who receives benefits on an aid basis, that that comes to the individual who receives the same kind of charity—from a fund to which he may never have contributed a cent—but because it is a national tax it is not a charity, is a point that I would not be willing to accept, Senator Murray.

Senator MURRAY. Well, you are not opposed to the compulsory system because of its effect upon the medical profession; you do not oppose it because you think that under that system the profession will not fare as well as it does now. You oppose it, you claim, on the sole ground that it is socialization and that you oppose it as an American citizen, not as a doctor, because you think it is against correct principles. Is that it?

Dr. SENSENICH. May I correct you, Senator Murray? I am sorry I did not make it plain. I am not opposing it with reference to the pay of the physician. That is the point I made. But I am opposing it because a compulsory system has in every nation in the world led to the deterioration of medical care, and I am here in the interest of the public as well as the causes of medicine and I would take out of that the financial side.

The reason that I am not dealing there purely with theories, is that you can look to the records all over the world and find out what happened to the quality of medical care under systems of compulsion which you have described.

Senator MURRAY. Well, that is a question, of course, that has to be determined by itself. I think that, as a result of a compulsory system in various parts of the world, that people have been able to get medical care that they never previously got and that the general health of those countries has been vastly improved under compulsory systems of health and medical care.

I do not think there is any doubt about that and I do not think there would be any doubt about it in this country. We have millions of people in this country who are failing to get medical care today.

Dr. SENSENICH. What is your authority for that, Senator Murray? I do not want to be unkind, but that statement is made repeatedly and there is no proof of that.

Senator **Murray.** Well, it has been testified to before very frequently.

Dr. **Sensenich.** The sources of that information have not been established.

Senator **Murray.** I think it is recognized by the medical profession itself.

Dr. **Sensenich.** There are a few, but not these tremendously large numbers that are referred to from time to time. All those statistics that I know of came out of purely income tax stories, because they said they could not acquire—I did not mean to interrupt you, but if I may complete this—they said they could not have proper medical care under that income bracket. Now that has never been proved.

Senator **Donnell.** Will the Senator from Montana yield for one interpretation?

Senator **Murray.** I would like to finish this question.

Senator **Donnell.** Surely.

Senator **Murray.** When it comes to the service, from the records of the Selective Service during the war, it has been discovered that as a result of lack of adequate medical care, millions of our young people in this country are defective and deficient in health.

Now, that is the situation in a country where we have the present existing system of medical care. It does seem to me that if we had some system where a family could go and have their children examined and treated and taken care of, that this could have been largely avoided in this country.

It seems to me that that is an indication that there are millions of people going without adequate medical care and hospitalization in this country.

Records were introduced in previous hearings on this. I have before me a pamphlet entitled "Wartime Health and Education" which is an interim report of the Subcommittee on Wartime Health and Education, prepared for the Committee on Education and Labor of the United States Senate, pursuant to S. Res. No. 74, a resolution authorizing an investigation of the educational and physical fitness of the civilian population as related to the national defense.

This pamphlet contains evidence corroborating what I have just stated.

Dr. **Sensenich.** May I say, Senator Murray, that I appeared—I think you will find me in that same booklet or one other one—and I remember that discussion very well. If you approach this thing from a realistic standpoint, or if you have been furnished this information, it was admitted by those who had to deal with the medical examination of the draft men, that after all, the rejections were largely for conditions that were not remediable and could not have been taken care of at any time had the individual asked for medical care.

The largest number of rejections was due to mental conditions and to vision and to teeth. I could give you those in order. I can give you a complete report on it if the committee wishes.

Anyway, no medical attention could have made any difference. Furthermore, when a group was selected having remedial conditions and an effort was made to provide the medical care which might have made them eligible for the draft, for instance, the correction of hernia or so and so, they refused to have them until even the President was willing to admit at that time that it was useless to make any effort to correct these conditions because the yield of men made available for military service was so small as to make it not worth while.

Now, furthermore, the mental inadequacies—we could not do anything about that and nothing could have been done. So that——

Senator MURRAY. Mental inadequacy?

Dr. SENSENICH. Yes; the largest number of rejections were for mental and neuropsychiatric conditions for which nothing could have been done, medically, at any stage.

Senator MURRAY. Is that not, in some degree, attributable to the lack of medical care and lack of proper treatment at the proper time?

Dr. SENSENICH. No, no; Senator Murray. The group that—and I could go into that in detail and I would be very happy to——

Senator MURRAY. I do not wish to take up your time to do that.

Dr. SENSENICH. Senator Murray, I would be very glad to report that information in detail if the committee wishes.

Senator SMITH. I think it would be very valuable for the doctor, who has made a study of the draft cases, if there is a schedule showing the various causes of rejection, to file it for the committee's information.

I want to thank Senator Murray for raising the questions. They are very important.

Senator MURRAY. I would like to have in the record at this point this interim report which I just referred to.

Senator SMITH. There is no objection. We will put that report in the record at Senator Murray's request.

(The report referred to follows:)

**[Senate subcommittee Rept. No. 3, 80th Cong., 2d sess.]**

## WARTIME HEALTH AND EDUCATION

## INTERIM REPORT

[Pursuant to S. Res. 74]

REPORT TO THE SENATE COMMITTEE ON EDUCATION AND LABOR FROM THE SUBCOMMITTEE ON WARTIME HEALTH AND EDUCATION

We have the honor to submit herewith the third interim report of the Subcommittee on Wartime Health and Education.

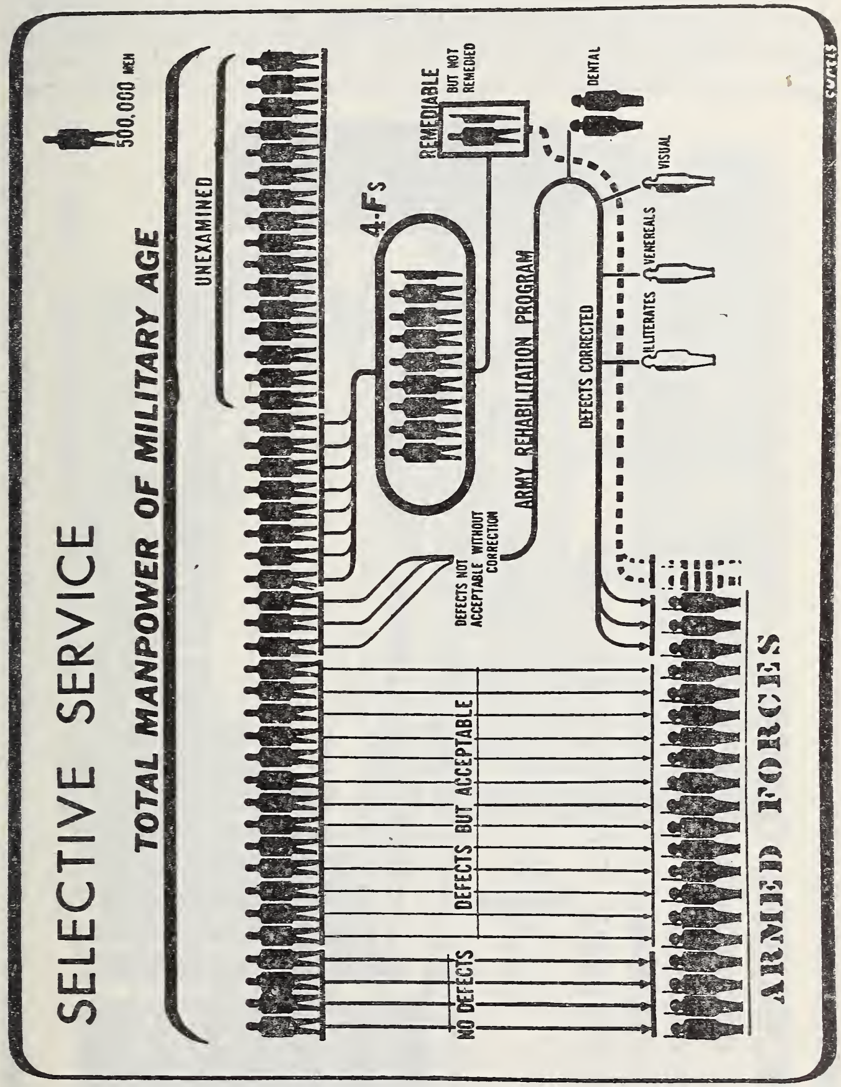
### THE 4½ MILLION IV–F'S

The Nation has been deeply impressed by the fact that approximately 4½ million young men in the prime of life have been found unfit for military service because of physical and mental defects. In addition, more than a million men have been discharged from service because of defects other than those sustained in battle. One and one-half million men now in uniform were rendered fit for service only through medical and dental care given after they were inducted.

In all, it is estimated that at least 40 percent of the 22,000,000 men of military age—between 8 and 9 million men—are unfit for military duty. This is more than twice the number of men we now have overseas engaged in the great offensives that will bring total victory.

The 4½ million men in class IV–F are those who remained unfit for military service after all doubtful cases had been reexamined in terms of the latest revision of Army and Navy physical and mental standards, after induction of those acceptable for rehabilitation in the Army and Navy, and after reclassification of all who by self-rehabilitation or other circumstances had become eligible for military duty. It should be emphasized that these 4½ million men are all rejectable under the lowest possible physical and mental standards, as defined by a special commission of physicians appointed by the President.

Interpretation of the Selective Service rejection data as an index of national health was challenged at the subcommittee's hearings by representatives of the American Medical Association. They pointed out that the standards of physical fitness demanded for military service are considerably higher than those required for normal civilian activity.

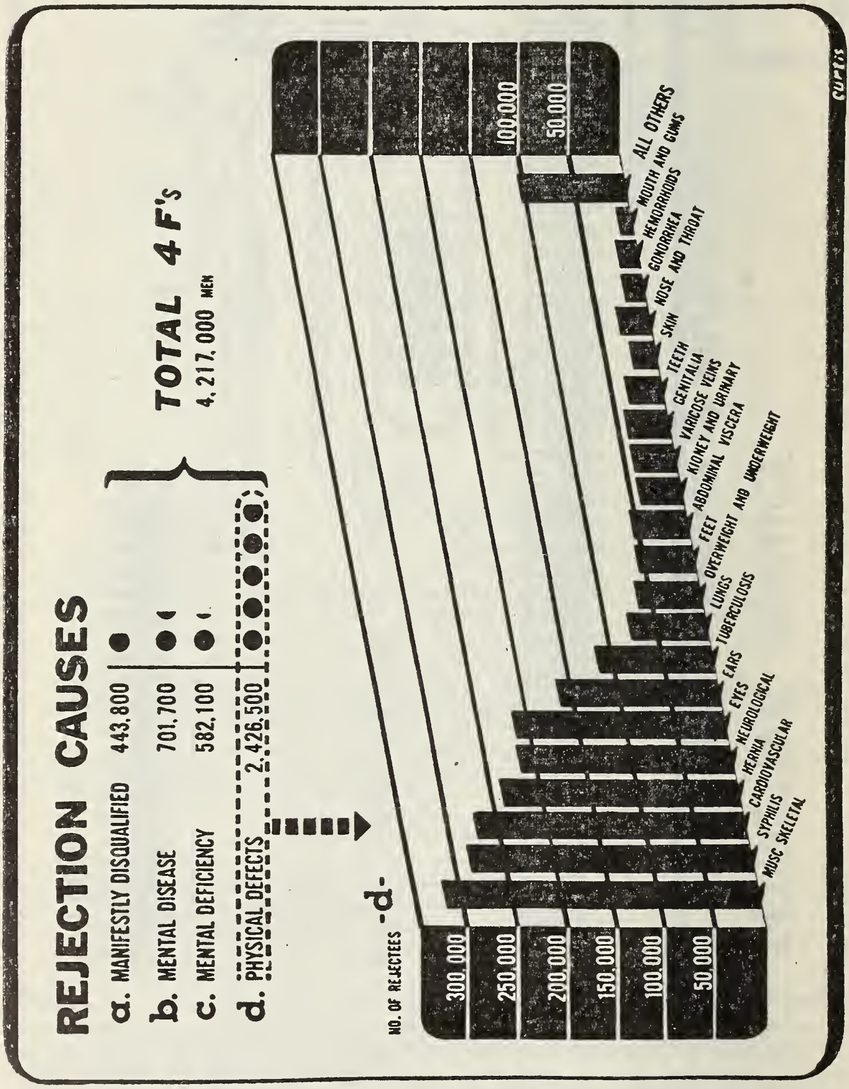

SELECTIVE SERVICE
500,000 MEN
TOTAL MANPOWER OF MILITARY AGE
UNEXAMINED
4-Fs
REMEDIABLE
BUT NOT REMEDIED
DENTAL
VISUAL
VENEREALS
ILLITERATES
DEFECTS CORRECTED
ARMY REHABILITATION PROGRAM
DEFECTS NOT ACCEPTABLE WITHOUT CORRECTION
DEFECTS BUT ACCEPTABLE
NO DEFECTS
ARMED FORCES

While it is true that many people are afflicted with defects that do not prevent participation in ordinary activities, such defects often reduce initiative and working capacity, and, if neglected, may eventually result in serious illness or disability. Certain minor defects of this kind may not appreciably affect mortality and morbidity rates, or life expectancy tables, and they may offer little of interest to physicians engrossed with more spectacular ills. But the patient with a toothache, or with impaired hearing, is well aware of the distress and limitations imposed upon him by his infirmity. In the aggregate, minor defects constitute a serious drain on our manpower.

Regardless of how the Selective Service data are interpreted, the widespread existence of illness and defects among our population has been demonstrated by numerous extensive surveys conducted under both governmental and private auspices. The findings of some of these surveys, which also have shown that many of thee diseases and defects are preventable or remediable with proper medical care, will be cited later in this report.

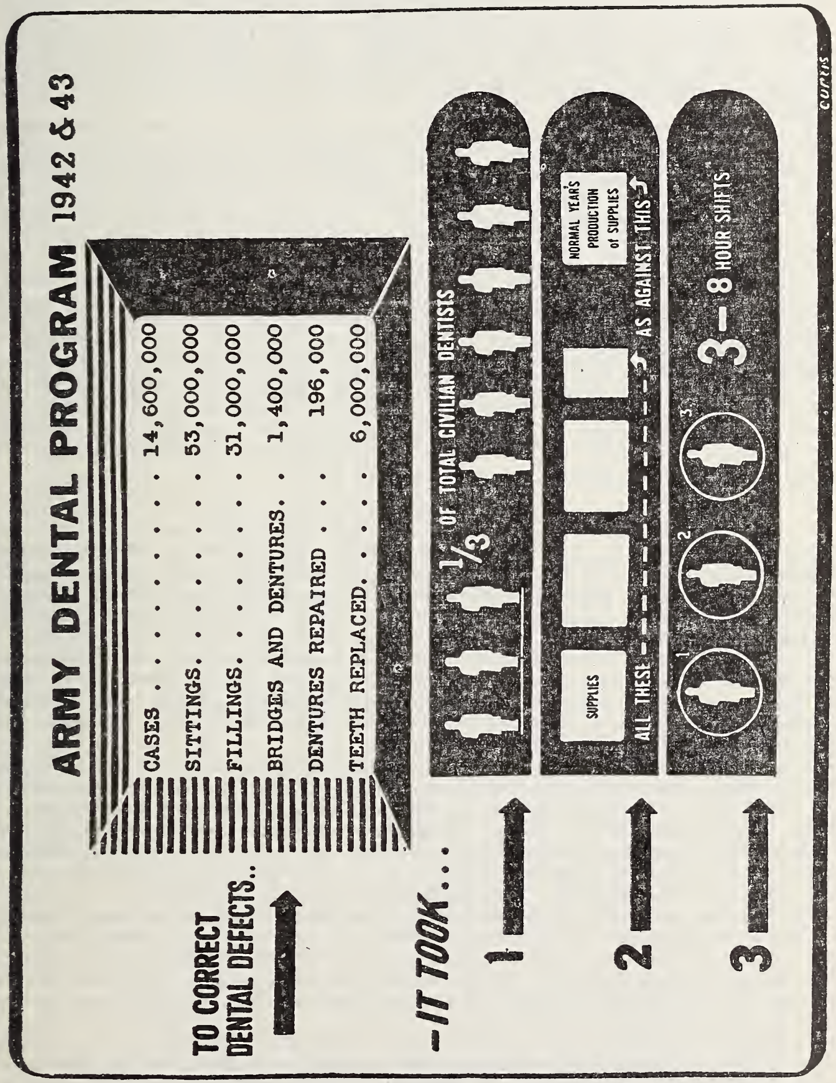
MEANING OF THE FIGURES

It would be wrong to conclude from the Selective Service rejection figures that we are a Nation of weaklings. Our enemies labored under that delusion, and they are learning their error the hard way. On the other hand, it is evident that we have no reason to be smug or complacent about the state of our people's health. We must ask, "What do these figures mean?" and then, "What must we do about it?"



It is clear that the figures do not reflect discredit on the men themselves. The great majority of them are the victims, not the villains, of the situation. Nor do the figures mean that the rejectees are unfit, for participation in the war effort; in most cases they are serving honorably in war production or in some other necessary civilian activity.

The large number of rejections does mean that the manpower problems of the Army and Navy have been much more serious than they would have been had the Nation's health been better. The unavailability of the rejected men means that it was necessary to call into military service hundreds of thousands of other men better fitted for essential civilian tasks and more deeply committed to responsibilities in the society we fight to preserve—men with families, trained mechanics, skilled technicians, and teachers in scientific and technical schools.



If this situation was preventable—and we are profoundly convinced that it was—this Nation has an immediate duty to seek an immediate remedy.

### REHABILITATION OF REJECTEES

According to officials of the Selective Service System, at least one-sixth of the defects for which men were rejected could be remedied with relative ease, as far as medical science is concerned, to fit them for general military service.

Early in the war, test rehabilitation programs were undertaken by the Selective Service System, but they yielded meager results and were abandoned. In sharp contrast to the results of the selective service efforts are those of the Army rehabilitation program. Here remarkable success has been achieved. Approximately 1½ million men with major defects have been inducted and rendered fit for duty, including 1,000,000 men with major dental defects, more than 250,000 with impaired vision, 100,000 with syphilis, and more than 7,000 with hernia. The success of this program demonstrates what can be done by vigorous and coordinated effort.

The magnitude of the Army's total dental program is apparent from the following figures: During 1942 and 1943, more than 14½ million cases[1] were treated, 31,000,000 fillings were provided, 6,000,000 teeth were replaced, and nearly 1½ million bridges and dentures were supplied. This work required 53,000,000 sittings by patients, and the production of three and one-half times the normal quantity of dental supplies and equipment produced in the United States in any one year.

We are told that registrants will continue to be called into service even after VE-day. Since the only physically fit men available will be the newly registered 18-year-olds, men with dependents, and those in essential occupations, wisdom and fairness demand that as many as possible of the registrants now in the IV–F classification be made fit for service. The subcommittee therefore recommends that the Army continue and, if feasible, expand its rehabilitation program.

Another opportunity for better rehabilitation service is presented by the Barden-La Follette Act (Public Law 113, 78th Cong.). This act recently made Federal funds available to State rehabilitation agencies for medical correction of defects hindering employment. Some IV–F's have already been referred by selective-service boards to State vocational rehabilitation agencies and have had their defects corrected. The immediate possibilities of this mechanism are somewhat limited because initiative is in the hands of the individual States, many of which have not yet developed the medical phase of their rehabilitation programs. Nevertheless, if the opportunities offered by the Barden-La Follette Act program were more widely known and utilized, more substantial progress could be made in the rehabilitation of rejected men.

### HEALTH OF THE REST OF THE POPULATION

According to the National Health Survey, conducted by the United States Public Health Service in 1935, more than 23,000,000 people in the country had a chronic disease or a physical impairment. In the working-age group (15–64), more than 3,000,000 people had impairments such as deafness, blindness, or orthopedic handicaps, and more than a million were estimated to have hernia.

A Farm Security Administration study of 11,495 individuals in 2,480 farm families residing in 21 typical rural counties in 17 States in 1940 showed that 96 percent of those examined had significant physical defects. The average number of defects per person was 3½. Only 1 person out of each 100 examined was found to be "in prime physical condition."

Among nearly 150,000 young people examined by physicians for the National Youth Administration in 1941, 85 percent needed dental care, 20 percent needed eye refractions, 19 percent needed tonsillectomies, and 12 percent needed special diets. Approximately 1 youth in every 7 was in urgent need of some kind of medical or dental treatment. About one-third of the young people had health defects which limited their employability. Only 10 out of each 100 examined had no defects for which the examination made a recommendation.

High defect rates are not limited to low-income groups such as those studied by the Farm Security Administration and the National Youth Administration. The Life Extension Institute, in examinations of 300,000 insurance policyholders selected indiscriminately with regard to sex, age, and occupation, found that 59 percent were so physically impaired as to need the services of a physician at the time of examination.

Industrial casualties take a heavy toll. From Pearl Harbor to January 1, 1944, 37,600 American workers were killed on the job—7,500 more than the military dead for the same period. More than 200,000 workers were permanently disabled and 4½ million were temporarily disabled.

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[1] The word "cases" as used here does not refer to individuals; an individual may have been recorded more than once as a "case" for separate treatments at the same or different Army posts.

### EFFECT OF ILLNESS ON WAR PRODUCTION

The profound influence of illness and disability on war production is illustrated by figures or work absences due to sickness and accidents. In 1943, the average male industrial worker lost 11.4 days and the average female industrial worker 13.3 days of work due to sickness and injury. By far the greater proportion of this loss—80 percent in the case of men and 90 percent in the case of women—was believed to be due to common ailments. Application of these figures to the number of employed male and female workers in the United States today indicates a loss of more than 600,000,000 man-days annually. This is about 47 times the amount of time lost through strikes and lock-outs of all kinds during 1943.

Intensive investigation and the testimony of many expert witnesses has convinced the subcommittee that a great deal of illness and disability could be avoided if the benefits of modern medical and public health science were made readily available in all sections of the country and to all persons regardless of economic status. In recent years, and especially since the outbreak of war, there has been a great awakening of public interest in all matters pertaining to health. More than 10,000,000 men and women in the armed forces are now receiving the benefits of complete medical and hospital care. The advantages of such care will not be forgotten after the war. Considerable increase in the demand for medical care may therefore be expected in the post-war period, and we should plan immediately to meet this increased demand.

On the basis of the information it has gathered to date, the subcommittee is not prepared to formulate a complete national health program or to make detailed recommendations concerning all the health problems that remain unsolved. In this interim report, however, we shall make preliminary observations regarding certain basic subjects which require further study; we shall also make specific recommendations regarding provision of facilities and services which we believe to be prerequisites to better national health and physical fitness.

### NEED FOR IMPROVED PREVENTIVE SERVICES AND FACILITIES

During the period 1900–1940, the death rate in the United States fell from 17.2 per 1,000 population to 10.8 per 1,000, a reduction of nearly 60 percent. Improvement has been most notable with respect to diseases which respond favorably to better sanitation and immunization procedures. The death rate from typhoid and paratyphoid fevers, for example, was reduced by 97 percent, from diarrhea and enteritis by 92 percent, and from diphtheria by 97 percent.

A major share of the credit for this remarkable progress belongs to the public health agencies of Federal, State, and local governments. The development of the preventive services furnished by these agencies, however, has been very uneven in different sections of the country. As recently as 1935, only 615 of the 3,070 counties in the United States had full-time local public-health agencies. By 1942, under the stimulus of Federal grants made available by the Social Security Act, the number of counties served by such agencies had approximately tripled. Today, however, about 40 percent of the counties of the United States still lack full-time local public-health service. Many of the existing health departments are inadequately financed and staffed. Minimum preventive services under the administration of full-time local public health departments staffed with qualified personnel should be provided in every community. To accomplish this, additional Federal financial aid would probably be necessary. If new and consolidated areas of local health administration were established, however, as suggested by the American Public Health Association, the total funds needed probably would not exceed greatly the present total of health department expenditures.

Complete geographic coverage by full-time local health departments would not be sufficient in itself, however, to enable us to take full advantage of the possibilities for further advances in the control of venereal infections, tuberculosis, malaria, and other preventable diseases. Funds are needed for expansion of health-department activities in these fields and many others, such as food and milk sanitation, industrial hygiene, maternal and child health, and health education.

### WATER SUPPLIES, SEWERAGE, AND RURAL SANITATION

The progress made in the control of filth- and water-borne diseases should not blind us to the fact that many communities lack adequate sanitary installations and that rural sanitation in many parts of the country is at a deplorably low level. According to the United States Public Health Service, nearly 5,000 communities need new water systems and approximately 6,500 need water extensions or improvements. New sewerage systems are needed in about 7,700 communities with a combined population of nearly 9,000,000. More than 10,000,000 additional people live in communities where sewer extensions are needed. There are more than 2,800 incorporated communities, with a total population exceeding 25,000,000, that do not have any form of sewage treatment. Approximately 5,250,000 rural homes need new or improved water supplies, and 5,000,000 need sanitary privies. More than 846,000 rural homes do not have so much as an outdoor privy.

The importance of milk as a vehicle for transmission of disease is universally recognized. Although pasteurization can and does prevent the transmission of milk-borne disease, most of the milk used in smaller communities is still consumed raw. Pasteurization plants should be constructed in more than 400 small communities with an aggregate population of about 1,666,000.

In many instances, community facilties such as those mentioned above could be financed on a self-liquidating basis by local governments with the aid of technical assistance and long-term, low-interest loans from State and Federal Governments. In other cases, grants-in-aid would be needed to supplement local resources. Such loans and grants would pay high returns in better health for all the people and in civic improvement throughout the Nation. Moreover, the required projects would give substantial stimulus to industry and would help provide full employment after the war.

### IMPORTANCE OF CHILD HEALTH

Most of the witnesses who testified before the subcommittee emphasized the necessity of correcting physical defects early in the life of the child. The importance of this is illustrated clearly by a study conducted by the United States Public Health Service in Hagerstown, Md. The health of the school children in Hagerstown has been observed over a period of years, and careful records of the findings have been kept. Recently, the selective service medical records of the Hagerstown registrants were compared with the school health records obtained by examination of the same individuals during their childhood. The comparison showed that many of the defects for which registrants were rejected had been discovered as much as 15 years earlier while the registrants were students in high school and grade school, and that in the years intervening between the school health examination and the selective service examination many of the defects remained uncorrected and unimproved. Seventy percent of those rated poor in nutritional status were rejected 15 years later.

The Hagerstown story is a familiar one to many physicians who freely give their time and energy in annual examination of school children. Every physician who conducts such examinations knows the discouraging experience of seeing his recommendations for the correction of physical defects go unheaded. In many children the same defects are noted year after year, and nothing is done about them. Obviously, more effective methods of following up doctors' recommendations are needed. A prerequisite to the achievement of better results is the removal of financial barriers to fulfillment of such recommendations. The opportunities for supervision and promotion of children's health in the school are so great that no effort should be spared to develop methods by which present neglect can be overcome. The Nation's and the Government's rightful concern in this matter is demonstrated by the unfitness of millions of young men in a time of national crisis, and the subcommittee plans to investigate the subject further.

### MENTAL HYGIENE

The high rejection and discharge rates for so-called neuropsychiatric causes have focused Nation-wide attention on the prevalence of mental disorders and maladjustments. This subject will be dealt with in a separate report on the health needs of veterans. We wish to emphasize here only the following points:

There is no cause for special alarm at this time about the number of neuropsychiatric discharges. A high rate of rejection and discharge for neuropsychiatric causes could have been predicted. It has long been known that a large proportion of the illness encountered in general medical practice is essentially neuropsychiatric in origin and that half of the patients in hospitals at any one time are there because of serious mental disorders. Indeed, one may safely predict that in any group of 15-year-olds 1 out of 22 will some day be a patient in a mental institution. It is not surprising, therefore, that the Army and Navy have had to reject and discharge large numbers of men as unfit to cope with the unusual stresses and strains of military life.

The neuropsychiatric causes for rejection and discharge include various degrees of nervousness, emotional instability, personality disorders, and inadequacies. The great majority of men with these difficulties can adjust themselves satisfactorily to civilian life in the home, on the job, and in the community. As indicated by a recent study of the New York Committee on Mental Hygiene, however, many of the men will need professional psychiatric services to help them make the adjustment. At present, psychiatric clinics are altogether inadequate to meet the needs of the returning men, and considerable expansion of such clinical services should be undertaken, primarily as a preventive measure to guard against the aggravation of disorders which are now relatively minor. The acute shortage of trained psychiatric personnel makes it imperative that such expansion be accomplished within the framework of general community medical services rather than as a separate program for care of veterans. There are only 3,000 qualified psychiatrists in the country, too few to permit separate mental hygiene services for different segments of the population. Medical schools could help by arranging their curricula so that the general medical practitioner, who must see most of the patients with psychoneuroses, would have a better knowledge of phychiatric problems and techniques.

From a longer range point of view, the establishment of child-guidance clinics in all communities is urgently needed to prevent early social maladjustments. Such a step would pay tremendous dividends in decreased crime, delinquency, and costs of institutionalizing the mentally ill.

Finally, attention must be drawn to a factor which is beyond the control of medical science. Many expert witnesses emphasize that full employment and adequate social security are indispensable to a truly effective health program. This is especially so in regard to mental health. There is nothing so detrimental to a person's morale and self-confidence as idleness and the feeling that he has no useful place in the scheme of things. It may be too much to say that idleness causes mental or physical disease, but it provides fertile ground for development of fears, anxieties, and a sense of insecurity. These factors are known to have a profound effect on man's resistance to disease.

## MEDICAL EDUCATION

Certainly, from the point of view of future needs, there should be no reduction in the present output of trained medical personnel. According to the American Medical Association, curtailment of this output is threatened. Bcause of the urgent need of the armed forces for young men, the Selective Service System has deemed it impractical to continue occupational deferment of premedical and predental students. For the same reason, the Army Specialized Training Program for premedical and predental students has been drastically curtailed. By 1946, medical schools will have to depend upon civiilan enrollments for 93 percent of their incoming students. The American Medical Association estimates that enrollment of medical students may fall as much as 50 percent beginning with the class entering in 1945. If this proves to be the case, there will be only 2,500 medical graduates in 1948, about half the usual number, and about 1,000 less than the number of physicians who die annually. The chairman of the executive council of the American Association of Medical Colleges states that not all schools got a full quota of students in 1944, and he predicts that many schools will have marked decreases in their 1945 entering classes. All expert opinion, however, is not so pessimistic. The former chairman of the executive council of the Association of American Medical Colleges has informed the subcommittee that medical-school administrators are not alarmed about the situation. Further study of the facts is apparently necessary.

If there is actually a threatened shortage, it would seem that there must be in the Unitd States the few thousand persons of the age, caliber, and training needed to raise annual premedical and medical-school enrollments to the number required for the duration of the war emergency. It is true that an increased effort would have to be made to find students. Many war veterans and young men rejected for military service because of physical defects do not know of the great need for doctors or of the opportunities present in the study of medicine. Moreover, certain barriers and prejudices which limit enrollments could be removed. The financial barriers which face many prospective students could be overcome by more adequate scholarships or by loan funds. Some qualified students cannot gain admission to medical schools because of tacit racial or religious discrimination. Lastly, there is a great untapped source of future doctors among the women of the Nation. We are unable to discover any compelling reason for the failure of this country to utilize its womanpower to prevent what is claimed to be a serious future shortage of physicians. Other nations have done so; we have simply never tried.

### TRAINING FOR DEMOBILIZED PHYSICIANS

The quality of medical education in this country for the past two decades has been very high. The medical schools have rendered outstanding service in the war by increasing the annual output of physicians 30 percent despite serious depletion of faculties and unpredictable Army and Navy policies. But the accelerated undergraduate courses, and the shortened internships and residencies, will make it necessary to provide further supervised training for many recent graduates unless the future quality of medical and dental practice is to be jeopardized. Most of the young graduates are well aware of this. A majority of the replies to a questionnaire recently addressed to medical officers of the Army and Navy indicated a desire for refresher and advanced courses in medicine after the war. Neither the need nor the demand for postwar advanced medical training can be met with the graduate teaching facilities and staffs now available in medical schools. Expansion of such facilities through increased provision of teaching hospitals and medical centers, as part of the program hereinafter described and recommended, will therefore be required.

Many thousands of physician veterans will receive postgraduate training at Government expense under the terms of the G. I. Bill of Rights. Additional financial assistance will be necessary for many of those eligible if they are to avail themselves of training opportunities offered. For example, it is unlikely that a doctor with a wife and two children could maintain himself very long on $75 a month.

### DISTRIBUTION OF MEDICAL FACILITIES

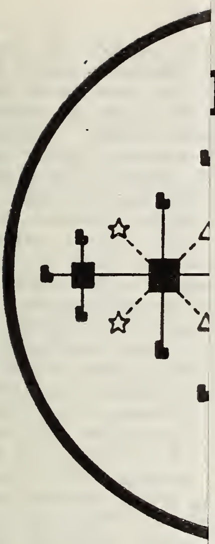
The quality of American medicine at its best is very high. Unfortunately, American medicine at its best reaches only a relatively small part of the population. One of the greatest benefits of modern, scientific medicine is the early detection of conditions which, if neglected, may become seriously incapacitating or even fatal. Vast improvement is needed in the application of known diagnostic procedures. Only a negligible proportion of people get a periodic physical check-up. Fifty-five percent of all cases of tuberculosis admitted to sanatoria are in an advanced stage of the disease at the time of first admission. In mass chest X-ray studies of presumably healthy workers, at least one in every hundred is found to have significant tuberculosis. Many patients have cancer for months, or even years, before the disease is discovered, and a substantial number of cases remain undiagnosed until cancer has caused death. There is widespread neglect of prenatal care by which both maternal and infant death rates could be considerably reduced.

The reasons for the failure of medicine to apply more widely the known diagnostic and preventive techniques are many and complex. The economic barriers to care are discussed later. Another very important reason is the lack of physical facilities and equipment in many parts of the country. Good medical practice today requires a concentration of skilled personnel and equipment that is found only in good hospitals, medical centers, or group clinics.

Whereas the national ratio of general hospital beds was 3.4 per 1,000 population in the years just before the war, the ratios in such States as Mississippi and Alabama were less than half that. According to the Surgeon General of the United States Public Health Service, 40 percent of our counties, with an aggregate population of more than 15,000,000, have no registered hospitals. Many of the counties with hospitals have poor ones, even though they are registered.

A study conducted by the American Medical Association showed that only 2 percent of the population did not reside within 30 miles of some hospital. Such a study, however, does not indicate the size or quality of the institutions, whether or not they have vacant beds, whether or not patients are financially able to use them, or whether racial barriers or legal requirements concerning residence prevent their utilization by all who live in the vicinity.

# ERVICE PLAN



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- TEACHING
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  - INTERNS
  - RESIDENTS
  - POST GRADUATE
- LABORATORY
  - X-RAY
  - PATHOLOGY
  - BACTERIOLOGY
  - CHEMICAL
- PHYSIOTHERAPY
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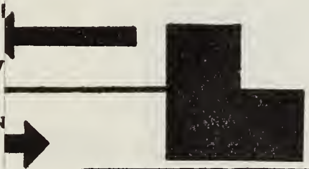
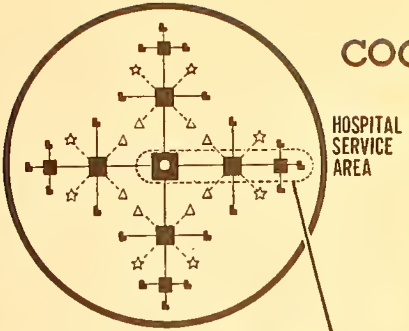


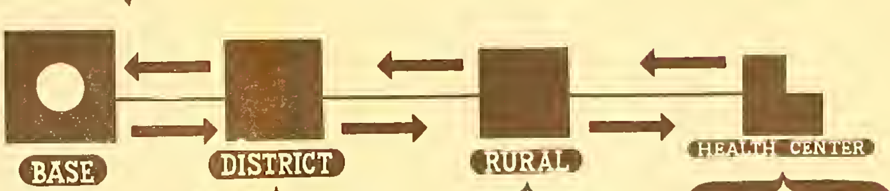
**HEALTH CENTER**

- OBSTETRICS
- EMERGENCY MEDICAL AND SURGERY
- LABORATORY
  - X-RAY
  - BACTERIOLOGY
- DENTISTRY
- PRIVATE OFFICE OR OFFICES FOR PRIVATE PHYSICIANS
- ADMINISTRATIVE PUBLIC HEALTH OFFICES
  - HEALTH OFFICER
  - SANITARIAN
  - PUBLIC HEALTH NURSES
  - PUBLIC HEALTH CLINICS
    - MATERNAL AND CHILD HEALTH
    - TUBERCULOSIS
    - VENEREAL DISEASE
  - PUBLIC HEALTH EDUCATION

# COORDINATED HOSPITAL SERVICE PLAN



■ HOSPITAL
▙ HEALTH CENTER
☆ INSTITUTION (CHRONIC DISEASE)
△ NURSING HOME (CHRONIC DISEASE)



**BASE**

Teaching Research Consultation

- CANCER CLINIC
- PSYCHIATRIC SERVICE
- HEART CLINIC
- MAJOR SURGERY
- INTERNAL MEDICINE
- OBSTETRICS
- PEDIATRICS
- ORTHOPEDIC SURGERY
- COMMUNICABLE DISEASES
  - TUBERCULOSIS
  - VENEREAL DISEASE
  - OTHER
- TEACHING
  - NURSES
  - INTERNS
  - RESIDENTS
  - POST GRADUATES
- LABORATORY
  - X-RAY
  - PATHOLOGY
  - BACTERIOLOGY
  - CHEMICAL
- PHYSIOTHERAPY
- DENTISTRY
- EYE, EAR, NOSE, THROAT
- DIETETICS

**DISTRICT**

- MAJOR SURGERY
- OBSTETRICS
- INTERNAL MEDICINE
- COMMUNICABLE DISEASES
  - TUBERCULOSIS
  - VENEREAL DISEASE
  - OTHER
- PEDIATRICS
- EYE, EAR, NOSE, THROAT
- DENTISTRY
- PHYSIOTHERAPY
- LABORATORY
  - X-RAY
  - PATHOLOGY
  - BACTERIOLOGY
  - CHEMICAL
- TEACHING
  - NURSES
  - INTERNS
  - DIETETICS

**RURAL**

- INTERNAL MEDICINE
- OBSTETRICS
- EYE, EAR, NOSE, THROAT
- DENTISTRY
- MINOR SURGERY
- LABORATORY
  - X-RAY
  - BACTERIOLOGY

**HEALTH CENTER**

- OBSTETRICS
- EMERGENCY MEDICAL AND SURGERY
- LABORATORY
  - X-RAY
  - BACTERIOLOGY
- DENTISTRY
- PRIVATE OFFICE OR OFFICES FOR PRIVATE PHYSICIANS
- ADMINISTRATIVE PUBLIC HEALTH OFFICES
  - HEALTH OFFICER
  - SANITARIAN
  - PUBLIC HEALTH NURSES
  - PUBLIC HEALTH CLINICS
    - MATERNAL AND CHILD HEALTH
    - TUBERCULOSIS
    - VENEREAL DISEASE
  - PUBLIC HEALTH EDUCATION

PLAN PROVIDES FOR CONSTANT EXCHANGE BETWEEN HOSPITALS OF INFORMATION TRAINING, AND CONSULTATION SERVICE, AND PERSONNEL, AND FOR REFERRAL OF PATIENTS WHEN INDICATED

### DISTRIBUTION OF PHYSICIANS

Shortages of doctors, dentists, nurses, and other medical personnel are marked in many communities, and, in general, medical personnel are inequably distributed throughout the country. For example, in 1944 Massachusetts had about 3 times as many active physicians in proportion to population as did South Carolina. Similar disproportions exist between other States and between local areas within the same State. Counties with more than 5,000 population may be without a single physician, while other counties in the same State may have 1 active physician for each 1,000 people.

Extensive studies conducted by the United States Public Health Service show that the distribution of physicians is influenced by several interrelated factors, among which are community purchasing power, adequacy of hospital facilities, degree of urbanization, proximity to medical schools and teaching hospitals, and presence of professional colleagues. Of these factors, the first three are probably the most significant, and community wealth is probably the most important of all. In 1938, counties with per capita income of more than $600 had 8 times as great a proportion of physicians to population as did counties with per capita income of less than $100.

Rural areas are generally less well supplied with physicians than urban areas. Strictly rural counties in 1938 had only about one-third as many physicians in proportion to population as did urban counties. Recent data supplied by the Procurement and Assignment Service show that the 81 counties reported to have no active physician, as well as the 141 counties reported to have more than 5,000 inhabitants per active physician, were practically all rural. The wealthier rural areas are better supplied than are the poorer rural areas, but even the wealthiest group of rural counties in 1938 had 30 percent fewer physicians in proportion to population than urban areas with the same per capita income.

The shortage of physicians in rural communities is not due to less need for medical care than in cities. Studies made by the Farm Security Administration suggest that the burden of illness in rural areas is the same as, or greater than, in urban centers.

### SITUATION GROWS STEADILY WORSE IN RURAL AREAS

Despite this need, medical graduates have shown increasing reluctance in recent decades to settle in rural communities. In North Carolina, for example, the number of doctors in strictly rural areas fell from 1,125 in 1914 to 719 in 1940, although the population in such areas increased from 1,960,000 to 2,597,000 in the same period. In 1940, 73 percent of the population of the State lived in rural areas, although such areas contained only 31 percent of the State's physicians. The burden of caring for rural patients falls increasingly on the older practitioners who, despite sometimes heroic efforts, are frequently unable to do the work demanded of them.

There is no doubt that lack of hospitals and diagnostic facilities is one of the most important factors in keeping doctors away from rural practice. In fact, the presence of hospital facilities alone, independently of such factors as community wealth and size of population, appears to attract physicians. This is suggested by a United States Public Health Service study which shows that among counties with per capita income of less than $300, those with no general hospital beds had 60 percent fewer doctors in proportion to population than did those with 250 or more general hospital beds.

Many crowded war-industry and extra-cantonment communities are also suffering from a severe shortage of doctors. In some places shortages have been relieved by relocation of physicians through the Procurement and Assignment Service of the War Manpower Commission, but in others the situation remains critical and without hope of relief except through assignment of Public Health Service physicians, a proposal which Congress has rejected. Data submitted by the Procurement and Assignment Service show that at the end of 1943, 553 counties had more than 3,000, 141 counties had more than 5,000, and 20 counties had more than 10,000 people per active physician in private practice. In addition, 81 counties, 30 of which had populations of more than 3,000, had no practicing physician.

The wartime shortages are merely sharper manifestations of the long-standing and steadily growing maldistribution described above. There is every indication that maldistribution will become even more marked after the war unless effective steps are taken to reverse the trend. As the older physicians who remain in rural communities die or retire the situation becomes increasingly critical. Polls of the opinions of young Army and Navy doctors show that the vast majority want specialist training and practice, preferably with a group. Only 12½ percent indicated a desire for rural practice. We may therefore expect the younger doctors and dentists to continue to shun the countryside unless they are offered good professional surroundings, including modern hospital facilities and an opportunity to earn a good living. Without such positive incentives the opportunity for better distributon presented by release of medical personnel from the armed services will be lost. More uniform licensure laws are also needed.

### THE MEDICAL CENTER IDEA

Hospitals were formerly considered only as places in which to care for the seriously ill, and even today many hospitals are nothing more than that. Modern programs of hospital construction should have as their aim the ample provision of a more inclusive type of hospital service. The subcommittee has studied with interest the growing trend toward utilization of a relatively new type of facility called a medical center, which combines and coordinates the three major aspects of modern medical care—the preventive, the diagnostic, and the therapeutic services. The medical center brings together doctors' offices, diagnostic and laboratory equipment, hospital beds, and preventive work. It furthers group practice by physicians, surgeons, and dentists; encourages experimentation and research; and stimulates dissemination and exchange of medical knowledge.

This principle of combining the preventive, diagnostic, and curative services of medicine into a single functional unit, here called the medical center, has been advantageously applied on a large scale in certain great university centers and in the Mayo, Lahey, Crile, Ross-Loos, Scott-White, and other group clinics. It is also applicable, however, to the smaller-scale needs of rural communities throughout the Nation. The establishment of a network of "outpost clinics," to use the phrase of a representative of the American Medical Association, the creation of "diagnostic centers," as urged by the Surgeon General of the Navy, and the "expansion of the present functions of the hospital," advocated by the spokesman of the American Hospital Association, appear to be expressions of the same basic aim—the provision of facilities suited to the practice of modern, scientific medicine.

### PLANNED NETWORK OF FACILITIES URGED

Terminology in this field is far from uniform. The Surgeon General of the United States Public Health Service urged development of a coordinated network of four basic types of medical center facilities—the small neighborhood or community "health center," the "rural hospital," the "district hospital," and the large "base hospital." (See cut.)

The physical structures required for many of these four basic types of units already exist in many areas. Here the primary need is for regional planning and organization of the existing facilities so that they might function in a coordinated manner, rather than for the construction of new buildings. In some places, minor alterations, renovations, or addition of new wings might suffice to convert existing public or voluntary institutions into units of the coordinated regional plan.

The smallest unit, the health center, might include offices for local physicians and dentists; facilities for emergency medical and surgical work; a small number of beds for obstetrical care; laboratory facilities for X-ray, blood, and bacteriological procedures; and health department offices and clinics where these are not otherwise provided.

The rural hospital, located within easy reach of several health centers, would be larger than the health center and would provide additional basic medical, surgical, obstetrical, and laboratory services. The size of the rural hospital would depend upon the needs of the area it served, but it should be a modern hospital in every sense of the word.

Many of the health centers and rural hospitals probably would serve areas which could not support specialists' services of their own. Therefore, such services would be provided through district hospitals, located so that they could conveniently serve several rural hospitals. Local needs and preferences might determine whether patients from the rural areas were transported to the district hospitals or whether the specialists from these hospitals visited the smaller units periodically. In most instances the district hospitals would provide nurse training and instruction for interns, including discussion of complex cases and of medical advances.

### BASE HOSPITALS

Finally, as the hub of each major medical service area, there would be a large base hospital. In most cases the major service area would be a State, though some States might have more than one major service area, and in some instances a base hospital might serve two States or sections of two States. The base hospital would be a teaching hospital, staffed with experts in every medical and surgical specialty, equipped for complete diagnostic services, and designed to conduct extensive postgraduate work and research. Besides its general hospital beds, it would have, either on its premises or nearby, facilities for institutional care and study of tuberculosis, nervous and mental disease, contagious disease, and orthopedic and chronic disease. The benefits of the research carried on in the base hospital would be passed on to the smaller units in the network, and there would be constant back-and-forth referral of patients and diagnostic information, as well as interchange of personnel, between the large center and the smaller institutions.

With such graded networks—the health center, the rural hospital, the district hospital, and the base hospital—covering the entire country, facilities would be available through which every person, regardless of where he lived, might receive (*a*) immediate diagnosis and care for the common, relatively simple ailments and (*b*) easy access when necessary to the more complicated types of medical service.

The development of such a network of medical centers would constitute a great step toward the goal of providing a high quality of medical service everywhere in the Nation. It would enable communities to cope much more adequately with the medical needs of war veterans and their families. It would also create opportunities for group and individual practice for the 40,000 medical and dental officers who will return from the armed forces, as well as for returning nurses and other health personnel.

### HEALTH DEPARTMENT CENTERS

Local health departments should be moved from the musty basements of county courthouses and city halls to modern, well-equipped buildings where the health officer and his staff could efficiently carry on their very important activities.

The American Public Health Association has proposed the creation of approximately 1,200 public health districts of roughly 50,000 population each, with at least one district health center and one subcenter in each district. These health department centers could in many instances be included in the medical center type of facility described above.

With improved facilities the health departments could undertake expanded public health programs designed to eradicate veneral disease, tuberculosis, malaria, and hookwork; to lower maternal and infant mortality; and to promote health through education. Cooperation would be fostered between the health department and local private practitioners, and both would benefit by a more comprehensive approach to the health problems of the people.

### ACHIEVING A HEALTH FACILITIES PROGRAM

According to conservative estimates made by the United States Public Health Service, facilities are needed for 100,000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds. In addition, 66,000 general beds, 97,000 nervous and mental disease beds, and 16,000 tuberculosis beds are situated in hospitals that are obsolete and that should be replaced. Approximately 2,400 modern structures are needed to serve as headquarters for local health departments. No estimates of need for chronic disease hospitals or mental hygiene clinics were given.

A program for construction of these facilities would have to be well-planned and well-coordinated, in order to avoid the mistakes which characterized the construction boom following World War I. Areas which need hospitals most should be given priorities for building materials and surplus medical supplies. The hospitals should not only be planned and built along modern, functional lines, but should be staffed and maintained so as to assure a high level of operating efficiency. Voluntary and public hospitals should work together in a coordinated manner. Both, in turn, should cooperate with the health department and private practitioners.

The cost of an adequate health-facilities program cannot be borne by the States and localities alone. Federal grants-in-aid to the States on a basis of need will be necessary.

In order to permit local initiative and control, State programs should be drawn up by State health planning commissions in cooperation with local authorities. Such commissions, consisting of representatives of professional groups and the public, could be appointed by Governors in States where they do not now exist. In drawing up State plans the commission should consider the needs of all sections of the State, should include in the plan all suitable existing public and voluntary hospitals, and should plot the new construction as well as the expansion or replacement of existing facilities needed for adequate service. Before Federal funds could be granted, however, over-all State plans and individual projects should be reviewed and approved by the United States Public Health Service to make sure that they meet certain minimum standards of construction, operation, and complete, coordinated service. There should be reasonable assurance that a new facility will have enough patients to justify its existence. In communities where sufficient income from fees of individual patients does not otherwise appear probable, provision for group pre-payment plans or tax-supported services, or both, should be required.

Grants to both public and voluntary institutions included in the plan would be administered through a State agency, in most cases the State health department. To insure continued representation of the public, health advisory councils should be appointed to confer with the State agency administering the plan.

### PAYMENT FOR MEDICAL CARE

Much has been said and written about the financial barriers to good medical care. There is general agreement that good medical care is necessarily expensive; that the burden of illness is unpredictable and falls unevenly, striking one family much harder than another; that sickness comes unexpectedly and may wipe out the laboriously acquired savings of an entire family; and that for these reasons and others a considerable part of the population does not receive either the amount or the quality of medical care it needs and should have.

In 1942 there were approximately 33.4 million family units in the United States. The following table shows their income distribution and the amounts they spent for medical care; also shown are the income distribution and the amounts spent for medical care by the 41.2 million "spending units," including individual consumers as well as family units:

*Income and medical care expenditures of 33½ million families and of 41 million spending units,[1] 1942*

| Aggregate money income during 1942 | Approximate number of families in each income group | Approximate number of spending units [2] in each income group | Percentage of total families | Percentage of total spending units | Average amount spent for medical care [3] | | Proportion of total income spent for medical care | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Families | Spending units | Families | Spending units |
| | | | | | | | *Percent* | *Percnet* |
| Less than $1,000 | 6,900,000 | 10,100,000 | 21 | 24 | $42 | $35 | 6.8 | 6.1 |
| $1,000-$2,000 | 9,800,000 | 12,600,000 | 29 | 31 | 68 | 62 | 4.5 | 4.3 |
| $2,000-$3,000 | 6,800,000 | 7,900,000 | 20 | 19 | 96 | 94 | 3.9 | 3.9 |
| $3,000-$5,000 | 6,700,000 | 7,300,000 | 20 | 18 | 143 | 141 | 3.7 | 3.7 |
| More than $5,000 | 3,200,000 | 3,300,000 | 10 | 8 | 241 | 241 | 2.4 | 2.6 |
| Total | 33,400,000 | 41,200,000 | 100 | 100 | 100 | 90 | 3.6 | 3.5 |

[1] Based on data from "Civilian Spending and Saving 1941 and 1942," Division of Research, Consumer Income and Demand Branch, Office of Price Administration (Mar. 1, 1943).

[2] The term "spending unit" includes individual consumers as well as families.

[3] Includes medical, surgical, hospital, dental, and nursing service.

The table indicates that even in the relatively prosperous year of 1942, 70 percent of the families in the United States had incomes of $3,000 or less and 50 percent had $2,000 or less. The average family expenditure for medical care was estimated at $100, but families with incomes under $3,000 spent considerably less than this. Nevertheless, the low-income families spent a larger proportion of their income for medical care than the higher-income families.

### CARE RECEIVED VARIES WITH INCOME

Other studies, particularly those of the Committee on the Costs of Medical Care, show that low-income families not only spend less for medical care but also receive much less care than those with higher incomes. The highest income group in 1929 received more than twice as much physician's care and more than three times as much dental care as did the lowest income group. Yet it is the low-income group that needs the most medical care. Sickness and poverty go together. In 1935 wage earners in families with incomes under $1,000 per year suffered about twice as many days of disabling illness as did workers in families with incomes over $3,000, according to the National Health Survey. Facts do not support the observation that "the poor and the rich receive the best of medical care; only the middle class suffers." High-quality care on a charity or low-cost basis is available to the poor in relatively few places. Even in those places, low-income families are often reluctant to accept charity.

In 1933 the Committee on the Costs of Medical Care estimated that adequate medical and dental care, with proper remuneration for those furnishing the service, could be provided at an average annual cost of about $125 per family under conditions of group practice. Since this estimate was made, prices of medical goods and services have risen so that the figure would probably be about $150 if it were brought up to date. Other authorities, basing their calculations on ordinary fee-for-service schedules, have placed the average cost of providing adequate services at a much higher figure. It is evident from studies of family budgets that the 50 percent of our families with incomes under $2,000 cannot afford to pay $150 a year for medical care and that this amount imposes hardship upon many families in the $2,000 to $3,000 income group. The result is that doctors' bills pile up and many people will not call a doctor until they are seriously ill.

### FEE-FOR-SERVICE VERSUS INSURANCE

Evidence such as this leads the subcommittee to conclude that the "pay-as-you-go" or fee-for-service system, which is now the predominant method of payment for medical services, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low incomes, whose need is greatest, are most likely to postpone or forego diagnosis and treatment.

The solution of this problem will not be easy. Undoubtedly it lies in some form of group financing which would make it possible to share the risks and distribute the costs more evenly. This might be achieved by voluntary or compulsory health insurance, by use of general tax funds, or by a combination of these methods. Insurance methods alone would not be enough, because they are not applicable to the unemployed or to those in the lowest income groups.

In order to meet the requirements of the public and of the professional groups concerned, any method which is evolved should offer complete medical care, should be reasonable but not "cut rate" in cost, should include substantially all of the people, should afford the highest quality of care, should permit free choice of physician or group of physicians, should allow democratic participation in policy making by consumers and producers of the service, should be adaptable to local conditions and needs, and should provide for continuous experimentation and improvement. Insofar as possible, it should also avoid the charity relationship.

### VOLUNTARY VERSUS COMPULSORY INSURANCE

The way in which these aims can best be achieved is now the subject of considerable debate. Advocates of voluntary health insurance, such as the Blue Cross hospitalization and the medical society prepayment plans hold that such plans will fulfill all needs if given sufficient time, and if supplemented by tax-supported grants for medical care to all recipients of public assistance. Others believe that only a small percentage of the population will ever obtain complete medical care through voluntary prepayment plans, and propose compulsory health insurance along some such lines as those set forth in the Wagner-Murray-Dingell bill (S. 1161, 78th Cong.). Still others maintain that needs would be met most satisfactorily and economically through a universal system of tax-supported medicine. At this stage of its investigation, the subcommittee is not prepared to pass judgment on these differing opinions. It is in agreement, however, with those who feel that remediable action is overdue and should not be long delayed.

Pending the achievement of a solution which will assure complete medical, dental, and hospital care for the whole population, more adequate provision should be made for medical care of the needy. This will require increased appropriations by local, State, and Federal governments. Under the Social Security Act, Federal funds are granted to State programs for aid to the needy aged, the needy blind, and needy dependent children. Federal funds can be used for medical care of individuals in these categories if the State law so provides, and in most States public-assistance budgets make some allowance for medical costs. By and large, however, the payments for medical care are utterly inadequate. Furthermore, Federal funds are not available to State programs for aid to needy individuals other than the aged, the blind, and dependent children. Legislation introduced in the Seventy-eighth Congress provided for amendment of the Social Security Act so that Federal and State funds would be available to help States finance medical care for the needy, regardless of category. Proposals have also been made to alter allotment procedures governing distribution of Federal funds to State public-assistance programs so that more money could be given to States where needs are greatest, and to allow Federal matching in programs which pay the practitioner directly. These measures, if approved, would help relieve the financial load on hospitals and practitioners, who now give a great deal of free care. Such relief for hospitals and physicians would permit them to lower their charges to prepayment plans and thus encourage the enrollment of more people from the group able to bear the average cost of medical care.

## MEDICAL RESEARCH

Magnificent progress has been made in medical research during the war. The curative powers of penicillin and of the sulfa drugs, the life-saving value of blood plasma and serum albumin, the efficacy of D. D. T. powder and typhus vaccine, and the development of new malaria-control methods are all fruits of a concentration and expansion of medical research resulting from determination to win the war. Adequate financing, coordination, and teamwork have been the keys to this success. Through governmental agencies such as the Army, Navy, and the Office of Scientific Research and Development, and non-governmental agencies such as the National Research Council, the universities, and other groups, the Nation's resources for research have been mobilized in a vast cooperative effort.

With victory in sight, we now approach the challenges of peace. Many problems await solution. Much long-term as well as short-term or "practical" research into the causes and cures of cancer, arteriosclerosis (hardening of the arteries), hypertension (high blood pressure), dental decay, and nervous and mental disorders must be undertaken in order to assure further progress against disease.

The Office of Scientific Research and Development has served well as an emergency agency through which to channel Federal aid for medical research. Federal aid must continue if the great possibilities offered by medical research are to be realized. The way in which Federal aid is to be given and administered must now be carefully considered.

Government cannot, and must not, take the place of philanthropy and industry in the sponsorship of research. It is essential, however, for the Federal Government to provide resources for coordinated attack on medical problems which affect the country as a whole. In no other way can science be given full freedom and opportunity to serve the Nation in peace as it has in war.

## EDUCATION, LEGISLATION, AND ORGANIZATION

The subcommittee recognizes the complexity of the task of providing good medical care to all the people. We believe that there are three necessary methods of approach to this task. One approach without the others would be unrealistic and ineffective.

The first involves education of the people, of the professions, and of the Government. We must collectively accept the fact of widespread existence of disease, disability, and injury, much of which medical knowledge today is able to prevent, alleviate, or cure.

The second approach is through legislation. For example, there is urgent need for modern medical facilities in many places throughout the Nation, especially in rural areas and in crowded war-industry communities. To meet these needs money must be provided, and Federal financial assistance will be necessary.

The third approach is through better organization of medical services. There is wide agreement that improved organization would result not only in a higher quality of service but in considerable economy of time, effort, and money. The necessary reorganization can best be achieved, and the welfare of the professions and the public advanced, by regional planning such as that provided for in the health and medical center proposal set forth above.

### RECOMMENDATIONS

On the basis of the preliminary findings outlined above, the subcommittee—

1. Recommends that Federal grants-in-aid to States be authorized now to assist in postwar construction of hospitals, medical centers, and health centers, in accordance with integrated State plans approved by the United States Public Health Service. (See cuts.)
2. Recommends that Federal loans and grants be made available to assist in postwar provision of urban sewerage and water facilities, rural sanitation and water facilities, and milk pasteurization plants, in communities or areas where such facilities are lacking or inadequate.
3. Urges State and local governments to establish full-time local public health departments in all communities as soon as the needed personnel become available. With this aim in view, consideration should be given to rearrangement and consolidation of local health jurisdictions and to amalgamation of existing full- and part-time local health departments with overlapping functions. The Federal Government should increase the amount of its grants to State health departments to the end that complete geographic coverage by full-time local health departments may be achieved and that State and local public health programs may be expanded in accordance with needs.
4. Recommends that the Army consider the feasibility and advisability of expanding its program for induction and rehabilitation of men rejected because of physical and mental defects; and that an emergency program of rehabilitation of IV–F's be undertaken immediately under the terms of the Barden-La Follette Act.
5. Recommends that the medical records of the Selective Service System be preserved and that funds be appropriated for further processing and study of these records.
6. Reports the acute shortage of personnel with training in psychology and psychiatry and the need for immediate steps to increase the output of such personnel with a view to providing child-guidance and mental hygiene clinics on a far wider scale.
7. Recommends that Federal scholarships or loans be made available to assist qualified students desiring medical or dental education; urges that increased enrollment of women in medical and dental schools, and premedical and predental courses, be encouraged in every way possible.
8. Recommends that Federal funds be made available to States for medical care of all recipients of public assistance and that allotment formulas governing distribution of Federal funds to State public assistance programs be made more flexible in order to given more aid to States where needs are greatest.

The recommendations made above should be put into effect as soon as possible. We should begin planning now for the reconversion period. Further delay will postpone orderly solution of our health problems and deprive us of an effective means of aiding industry to maintain full production and employment after the war.

A comprehensive health- and medical-facilities program, planned now and undertaken as soon as materials and labor become available, would soon pay big dividends in improved national health and physical fitness. We have seen what neglect of opportunities for better health has cost us during this war. We should resolve now that never again, either in war or in peace, will the Nation be similarly handicapped.

Claude Pepper.
James M. Tunnell.
Elbert D. Thomas.
Robert M. La Follette, Jr.

Senator **Donnell**. Is the Doctor familiar with the investigation made several years ago by the New Jersey Medical Society in regard to the question as to whether or not there is any considerable proportion of the population not receiving adequate medical treatment?

Dr. **Sensenich**. I heard about it at that time. I cannot quote from it at the moment but that was done and it was found that it was not due to medical neglect except on the part of the individual, at times, who chose to neglect it.

Senator **Smith**. Doctor, I suggest that you proceed with your report.

Dr. **Sensenich**. Yes.

Senator **Murray**. Mr. Chairman, I regret very much that I am compelled to leave at this point.

Senator **Smith**. I regret very much, Senator Murray, that you will not be here. I hope you will be here tomorrow morning.

Senator **Murray**. I wish to apologize to the Doctor, but I shall be very glad to read his testimony. I had very many meetings and conferences with him.

Dr. **Sensenich**. I enjoyed the discussion and I hope if we can furnish anything to the committee that will be helpful that you will ask us, as we would be very happy to do it.

Senator **Smith**. Thank you, Senator Murray.

You may proceed, Doctor.

Dr. **Sensenich**. I will just go through this hurriedly.

No social or legal measure can cover this field by any process of compulsion without in the end destroying the very qualities we seek to stimulate and develop in the individual. No social legislation containing these compulsions can be enacted without infringing upon the very basic qualities of American freedom. The only social measure compatible with the freedom of our American way of life is that providing opportunity to all and assistance where there is need. Administrators in high position will admit that governmental measures at the top, too far removed from the local community and the individual are, even with the best intent, clumsy and inadequate or restrictive in their final application.

So much is dependent upon the education, the interest and the voluntary effort of the individual that elevation of standards and program must be accomplished by local stimulation of effort and cooperation of these individual units in the community. Legislation cannot accomplish those ends. No pattern can be established at the national level that can be practicably applied to the varying conditions in each local community; nor can national regulations deal adequately and fairly in the determination of local need or the application of proper local remedies.

It is, therefore, evident that effective approach to the problem will rest upon the voluntary efforts awakened by stimulation of interest, and development of methods and assistance where need is demonstrated. It would seem that any legislation directed to this field would be largely concerned with providing financial assistance where need can be demonstrated and the setting up of safeguards to determine equitable distribution of that assistance. Contributions from State or local levels should be required in proportion to financial ability. It will be necessary to leave to the local community the administration of local measures without introduction of bureaucratic controls or political interference.

Then, I go on with the matter of voluntary prepayment plans and I will leave very soon so that Dr. McCormick can take that up because it is of great interest.

I refer to the bill S. 545 introduced by Senator Taft, Senator Smith, Senator Ball, and Senator Donnell as more nearly approximating a legislative background for the development of a health program for the American people without destroying or restricting the objectives set forth in the broad national health program of the American Medical Association.

I pointed to that because the American Medical Association has frequently been said to be obstructive. We do not obstruct except in those instances in which we feel action would be harmful to the public or against its best interests, and we do have a broad program which we are endeavoring to develop as rapidly as can be done.

The house of delegates of the American Medical Association has repeatedly taken action recommending the consolidation of the health activities of the Federal Government, exclusive of the Armed Forces and the Veterans Bureau, under a department of health, the head of that department to be a cabinet officer.

Senator SMITH. Doctor, if I may interrupt, do you imply by that that there should be a department of health, not associated with a welfare department? It has been suggested we have a cabinet officer covering welfare generally which would include health and so forth.

Dr. SENSENICH. We have opposed that for the reason that we feel that medicine would be in a subordinate position. I do not mean medicine, but health would be in a subordinate position.

And I follow through on that and I have with me here, if the committee cares, for your convenience, copies of the evidence that I gave before the other committee, the comittee on executive expenditures with reference to the Taft-Fulbright bill.

Senator SMITH. If that testimony is not too long, I think it might be inserted in the record.

Dr. SENSENICH. It is not very long.

Senator SMITH. Because this question will probably come up with this committee with regard to the separate health department or this other proposal.

I think we will just insert this statement from the American Medical Association at the hearing before the committee on the expenditures in the executive department. This is the testimony of Dr. Sensenich before that committee. That was in connection with S. 140 and it was a hearing of the committee on March 24, 1947.

(The statement referred to is as follows:)

## STATEMENT FROM THE MEDICAL ASSOCIATION SUBMITTED BY DR. R. L. SENSENICH, CHAIRMAN OF THE BOARD OF TRUSTEES

The American Medical Association includes more than 130,000 physicians who are members of the county and State medical societies. The policies of the association are determined by the house of delegates. The members of the house of delegates, numbering 175, are elected by the respective houses of delegates of the individual States, which in turn are elected by the members of the county medical societies. Thus the organization is democratic in its organization and in its functions.

The American Medical Association is this year completing 100 years of its existence, devoted to improving the standards of quality of medical service and broadening the distribution of the best medical care to all the people.

The American Medical Association has been in almost constant contact with most of the governmental agencies having to do with health activities, and has cooperated fully within the scope of policies agreed upon. The evident advantages of consolidation of widely scattered health activities prompted the board of trustees, in January 1937, to make the following recommendation: "The board of trustees of the American Medical Association would recommend that such health activities as now exist be so consolidated in a single department, which would not, however, be subservient to any charitable, conservatory, or other governmental interest.

"It has been repeatedly said that public health work is the first problem of the State. It is the opinion of the board of trustees that health activities of the Government, except those concerned with the military establishments, should not be subservient to any other departmental interests. This reorganization and consolidation of medical departments need not, under present circumstances, involve any expansion or extension of governmental health activities but should serve actually to consolidate and thus to eliminate such duplications as exist. It is also the view of the board of trustees that the supervision and direction of such medical or health department should be in the hands of a competently trained physician, experienced in executive administration." The house of delegates of the association approved the action of the board of trustees. The house of delegates in 1938 reiterated "its demand for a Federal executive department to be designated as the department of health, with a doctor of medicine at its head who shall have general supervision and direction of the affairs of the Federal Government pertaining to the health of the people."

In 1944, the house of delegates approved a resolution recommending that the functions of the Children's Bureau of the Department of Labor be transferred to the United States Public Health Service.

In the same session of the house of delegates, a resolution was adopted requesting "the Congress of the United States to create a Department of Public Health, the head of which department shall be a Cabinet officer, and to assign to such department all health activities of the Federal Government." These repeated actions of the house of delegates were conveyed to the Committee of the Senate on Expenditures in the Executive Departments in the Seventy-ninth Congress in the consideration of Reorganization Plan No. 2 of 1946.

It must be recognized that the American Medical Association throughout the years has maintained the closest contact and has directed continued study to the health activities of governmental agencies, Federal, State and local, educational and research institutions, voluntary groups, and philanthropic health agencies. It has also had the benefits of the experience and advice of unselfish investigators trained in the direction of health activities throughout the world. The reasons for the insistence upon the requirement that the health activities be under the supervision and direction of a "competently trained physician experienced in executive administration" and that the department be not "subservient to any charitable, conservatory or other governmental interest" is well founded.

The Federal Security Agency advances the following argument for the grouping of education, health, and security for the reason that the Federal Government has over a period of many years established agencies to deal with a variety of services to various groups of the population, referring particularly to the Department of Agriculture and those engaged in farming, the Department of Commerce with those in industry and management, the Department of Labor with workers in industry, Veterans' Administration for men with military service. The Security Agency then takes the position that "because each such agency was set up to serve a particular sphere of interest, no one of them is prepared to serve the citizen, and what is, after all, his fundamental character—as an individual human being. No one of them has a mandate to promote the basic concept of the general welfare—the welfare of people simply as people; their right to a firm base on which each can build his own assurances and pursue his own best interests."

The argument falls when it must be admitted by the Security Agency that the implication of effective broad general contact with the major portion of the population throughout the years is not well founded. It touches education only through the years in which compulsory attendance in school is required and that only through local autonomies over which it has little or no control. This is no doubt recognized by those who head the divisions of education.

Educational rehabilitation supported by Federal funds applies only to a relatively small special group, and its activities are carried on through State agencies. The same applies to special institutions. There may be other isolated small groups who are by reason of Federal aid to some degree come under the direction of the division of education. Social security includes only special groups in covered occupations, and other voluntary agencies collectively exceed the number thus included. Welfare, likewise, has a field of usefulness, but applies only to special groups and does not have universal contacts. Under Federal Security are some other agencies not directly classified under any of these headings, but, again, their number is determined by special needs. It is not intended in these comments to in any way belittle the excellent work being done or to reflect upon the heads of the various activities. However, it is necessary to have a realistic appraisal of the situation in considering the provisions of this proposed legislation.

Health activities must be directed to everyone throughout all of life and it must be noted that the years of major exposure, resultant illness, and greatest economic loss are the years in which the divisions of welfare and education have no effective contact. To discuss the individual as an individual apart from his environment is, to say the least, impractical and ineffective. Medicine extends its activities in the maintenance of health into all the areas of human activity, each one of which carries its own particular problem. Medicine must have the closest contact with all the other agencies of Government—the armed forces, veterans' agency, and other major bodies with which education and welfare have no important contact. If better health is to be attained, preventive health measures must be emphasized, and this will be accomplished on a basis voluntary to the individual who will not necessarily have any health contact with education, security, or welfare. Voluntary agencies are of the greatest importance.

All of the departments of Federal Security carry on through State agencies. Health activities have the most effective contact with the individual through State and local levels, and would receive relatively little benefit from combination with other Federal agencies. Health, welfare, and education operate individually at the State and local levels and there would be the greatest opposition to any effort to extend the control of the Federal agencies into the State level. Very large and important groups would prevent any extension of Federal bureaucracy and infringement upon the individuality and dignity of the citizen.

Medical research is likewise important to health progress. Productive research cannot be controlled by governmental agencies. Sufficient funds alone do not attract the brilliant research mind or insure effective research. There must be the closest professional contact, understanding, and cooperation between the voluntary agencies and professional individuals in order to accomplish desired results. It is not evident that welfare, education, and security, as established within the Federal Security Agency, would contribute to progress in medical research.

Medical achievements in the improvement of health, increase in the length of life, and betterment of the quality of living compare favorably with progress in any other scientific field, and the value of the contribution to cultural progress is beyond estimation. This field of activity, however, is highly specialized and cannot be confined within the area of welfare or economic security without loss of important factors in its continuing progress.

The American Medical Association has directed much study to the health needs of the Nation and has prepared a national program of 10 points covering the field of living conditions, fundamentals of good health, preventive medicine service and hospitalization, adequate care of mothers and children, facilities for diagnostic examinations, prepayment insurance plans, care of veterans, research, cooperation with voluntary health agencies, and health education.

Senate bill No. 545, introduced by Senators Taft, Smith, Ball, and Donnell, which provides for a separate health agency, would seem to more nearly approximate the standards of this national health program.

All health activities of the Federal Government should be concentrated in one division. That division should be "under the supervision and direction of a competently trained physician experienced in executive administration." Cabinet status would be desirable, but would be attained at too great cost of diminished effectiveness if the health activity were subordinate to another agency.

The American Medical Association will continue its efforts to attain the highest levels of health for all of the people.

Senator SMITH. You may continue. Doctor.

Dr. SENSENICH. The Department of Health should not be subservient to any charitable, conservatory, or any other governmental agency.

The American Medical Association opposes the inclusion of the health activities of the Nation in a Department of Health, Education, and Security, for the reason that an adequate national health program such as is now in process of development by the American Medical Association could not attain the high objectives sought, if it were combined in a Department of Welfare and Security. Evidence to this effect was presented in hearings before the Committee on Expenditures in the Executive Departments, United States Senate, Eightieth Congress.

You have copies of that testimony.

There is sufficient reason to maintain that the importance of the health activities is comparable to the importance of other departments and justifies the creation of a Department of Health of Cabinet rank. However, there is equal reason to believe that a national health agency without Cabinet rank could better serve the interest of the health of the Nation than the inclusion of the health activities with welfare or security, headed by a nonmedical Cabinet officer.

Senator DONNELL. May I ask the doctor if he has studied the provisions of S. 545 creating a national health agency?

Dr. SENSENICH. I have.

Senator DONNELL. And, generally speaking, are you favorable to the general terms of that section?

Dr. SENSENICH. The general terms; yes, sir.

Senator DONNELL. Yes?

Dr. SENSENICH. Yes.

In this brief statement, it is impossible to discuss very completely the various features of Senate bill No. 545. However, certain provisions of the bill should be particularly pointed out, notably, the bringing together of all scattered health activities into a national health agency headed by an outstanding physician; the determination of actual medical needs by requiring State surveys financed in part from Federal funds—this is a highly desirable feature—provisions of grants-in-aid to States also making some contribution for the extension of medical care to people unable to pay for it; the encouragement of voluntary prepayment plans; the provision for voluntary pay-roll deductions of Federal employees; periodic examinations of school children; and the provision for encouragement and grants-in-aid to certain types of research, properly directed.

These provisions of the bill should receive the approval of all those who are interested in a sensible approach to developing methods of extending aid rather than endeavoring to force upon the public a preconceived political pattern. It is noteworthy that no effort is made to establish criteria at the national level by which eligibility to a low-income classification shall be determined in each local community. Obviously, the section of the country and living costs in proportion to income will have material bearing on that matter.

That is the point I have objected to in the way of general statistics.

The appropriation of funds for the support of research in the prevention and control of cancer should be dependent as to the needs for continuation upon such cancer research as has been formerly under the direction of the Public Health Service. In other words, the situation might change if we have a committee appointed to deal with the over-all situation in research. I say here that if that committee should be appointed by the President to furnish a central point for coordination of all major cancer research programs, the proposed committee would not be for the purpose of restricting properly organized or equipped effort, but rather to prevent the useless expenditures of funds beyond the capacity of facilities or available competent research personnel to carry on that work. Such a committee might well function under this national health agency and might require substantial funds. However, it might be determined that the cancer research conducted under the Public Health Service might be reasonably expanded, but whatever is done should be in proper proportion and well coordinated with other cancer research. Those who are familiar with the research now being conducted and the capacity for expansion have advised of the useless waste of funds if appropriations exceed the amounts that can properly be expended.

As to the total amount to be authorized annually for a period of 5 years for the development of the plans for improved health service, it must be recognized that there are no criteria by which the exact amount necessary for this work can be definitely determined. Various figures have been offered along with other legislative proposals. These estimates are frequently predicated upon very limited sampling, and often suggest that they are influenced by unwarranted enthusiasm for their particular proposal, so widely do they differ from any other reasonable statistical source. The provisions of this bill seem to identify it as being a well planned and sensible approach to meet the needs which the whole Nation will recognize and approve as a necessary expenditure.

Senator DONNELL. Mr. Chairman, may I ask the doctor if any representatives of the American Medical Association have been consulted in regard to the contents of S. 545 before its submission to the Senate?

Dr. SENSENICH. They have.

Senator DONNELL. Would you just briefly state what you know about that consultation?

Dr. SENSENICH. The first draft of the bill had not had the opportunity for study, we thought, of the whole situation which the subject deserved and we were invited to discuss certain features of it and that was done.

Now, the present bill in some respects, as I have pointed out, departs a little from our idea and in the main, however, we are not fussy about the details so long as the general principle of extending aid where aid is needed and definitely demonstrated, and on the other hand to encourage the local communities to the greatest degree in the development of their own plans, and in their own financial support of those plans, is advanced.

So that, as a result of the ideas there, an opportunity was had for discussion.

On the other hand, this is definitely not our legislation. It is the legislation of the Senators who have submitted the bill and we are giving here publicly our approval to those features which we think meet with our plans.

Senator DONNELL. But, the American Medical Association was given an opportunity to make suggestions and consultations, was it not?

Dr. Sensenich. That is right.

Senator Donnell. And, on broad general principles, possibly leaving aside some of the details of the bill, the bill meets with the approval of the representatives of the American Medical Association who appear this morning—yourself?

Dr. Sensenich. Yes.

Just in conclusion, the provisions of this bill seem to identify it as being a well planned and sensible approach to meet needs which the whole Nation will recognize and approve as a necessary expenditure. The funds to be authorized under this legislation would obviously not be excessive and would vary as needs are determined or as local conditions make continuing aid to communities unnecessary.

We are not quibbling about the amount of money. No one knows how much money it will take but on the other hand that expenditure is necessary and we feel in the development of information and plans that it can be reasonably and cautiously permitted to grow as is necessary and it can be helpful. On the other hand, if we find it does not work, then modifications can be made.

Senator Smith. You approve completely, I gather, of the continuing experiment by the respective States in these fields to see if we can get more closely to adequate procedure?

Dr. Sensenich. Definitely, I do, Senator Smith.

Senator Donnell. Has this bill been submitted to the House of Delegates, or has it not had a meeting?

Dr. Sensenich. They have had no meeting since the final draft of the bill. However, it was discussed and considered in the last meeting of the House of Delegates. The Council on Medical Service, of which Dr. McCormick is chairman, was instructed to make studies. The board of trustees acts for the House of Delegates in the interim between meetings and they have authority and are so instructed and you have their approval.

Senator Donnell. Has the board of trustees met and considered this particular bill?

Dr. Sensenich. Yes.

Senator Donnell. Could I ask, just for the record, how large a body the board of trustees is?

Dr. Sensenich. The board of trustees is nine. There are nine trustees who represent the area of the United States, quite roughly geographically. The west coast, the east coast, the south, and so on.

Senator Donnell. Would you file, for our record, after you complete your testimony, a list of names of the members of the board of trustees and their respective locations?

Dr. Sensenich. Yes, I shall be very happy to.

(The list of members of the board of trustees of the American Medical Association is as follows:)

Dr. R. L. Sensenich, chairman, South Bend, Ind.
Dr. E. L. Henderson, Louisville, Ky.
Dr. Ernest Irons, secretary, Chicago, Ill.
Dr. Charles Roberts, Atlanta, Ga.
Dr. Dwight Murray, Napa, Calif.
Dr. William Braash, Rochester, Minn.
Dr. John Fitzgibbon, Portland, Ore.
Dr. James R. Miller, Hartford, Conn.
Dr. Louis Bauer, Hempstead, Long Island, New York City.

Dr. SENSENICH. The funds to be authorized under this legislation would obviously not be excessive and would vary as needs are determined or as local conditions make continuing aid to communities unnecessary. It is evident that the bill is not the promotion of a colossal plan of Government regimentation at tremendous cost such as has been proposed.

Placing the responsibility for the administration of these plans at the community level tends to a more personalized community administration and a better integration of the activities under this plan with voluntary agencies and other social developments.

We think that is quite important.

Senator DONNELL. That is other local social developments you are referring to?

Dr. SENSENICH. Yes; local, Senator Donnell.

Especially, it is important that the personal choice of physician be preserved and that nothing emanating from national Government levels be permitted to interfere with these local and personal medical aspects.

The provision for payments to physicians in the areas in which there would be insufficient income from professional services to attract a competent physician will require careful study. The study of these situations may be properly coordinated with the studying and planning for the establishment of facilities as authorized under the Hill-Burton bill. Advisory councils designated by the Governors of States may be helpful. Appointments to these positions should be made on the basis of competence and experience with sound medical guidance and not because of political preferences. Especially priorities given to certain areas in the development of facilities and establishment of plans probably will provoke more discussion than any other features of the administration of the act. However, if the personnel of the advisory council is carefully selected and has the respect and confidence of the public, this should not be unusually difficult. The advisory council has no authority other than advisory. The giving of some authority to the council might well be considered.

I am not sure as to that and I do not think it is so very important.

I do not wish to take the time of the committee in the presentation of technical data which would add nothing to the discussion and might tend to confuse rather than clarify the issues. The American Medical Association stands ready at any time to submit such detailed information as is available which the committee should desire or will provide more detailed reports of medical experience which might be helpful.

In summary, the bill seems to provide plans and means for the interweaving of Government and voluntary social and health agencies in such a manner as to permit the broadest variation in response to local needs. The American Medical Association is interested in the whole field of health and is desirous of bringing to every individual the benefits of the highest quality of medical care. It would seem that this bill will provide the legislative basis for meeting the needs of the lower income groups without imposing a huge, expensive system of regimentation with its inevitable destruction of the quality of medical service.

May I comment there that all those proposals are tremendously expensive—much more burdensome than anything we are here considering.

Senator DONNELL. By reference to "this bill" you mean S. 545?

Dr. SENSENICH. That is right.

Senator DONNELL. And you meant it in previous references to "this bill"?

Dr. SENSENICH. Yes, Senator Donnell.

It seems this bill would provide a legislative basis for meeting the needs of the lower income groups without imposing a huge, expensive system of regimentation with its inevitable destruction of the quality of medical service. The medical profession will continue its efforts toward development of its national health program and will oppose plans that are manifestly against the public interest.

Thank you very much.

Senator SMITH. Doctor, we are very grateful to you for the splendid presentation. We appreciate your being with us.

Thank you very much.

Dr. SENSENICH. Thank you very much.

Senator SMITH. I will ask Dr. McCormick to come forward.

Dr. SENSENICH. May I introduce Dr. McCormick.

(Dr. Sensenich submitted the following brief:)

## STATEMENT FROM THE AMERICAN MEDICAL ASSOCIATION SUBMITTED BY DR. R. L. SENSENICH, CHAIRMAN OF THE BOARD OF TRUSTEES

The American Medical Association, as of record May 1, 1947, includes 132,659 physicians who are members of the county and State medical societies. The policies of the American Medical Association are determined by the house of delegates. The members of the house of delegates, numbering 175, are elected by the respective houses of delegates of the individual States, which in turn are elected by the members of the county medical societies. The association, thus, is democratic in its organization and in its functions.

The American Medical Association has now completed 100 years of organized existence, devoted to improving the standards of quality of medical service and broadening the distribution of the best medical care to all the people.

The association, throughout these years, has directed continuing study and experiment to improving methods of undergraduate education in medicine, the organization of opportunities for postgraduate study and the creation of facilities for the provision of the best medical care, including service to the indigent and those of low income.

The direction of these efforts throughout the whole field of study and improvement of standards and methods has been characterized by close contact and cooperation with the health activities of governmental agencies, Federal, State, and local; educational and research institutions; voluntary groups; and philanthropic health agencies. The association has also observed closely the standards and methods of distribution of medical care in other nations and has had the benefit of the experience and advice of unselfish investigators trained in the direction of health activities throughout the world.

These broad consideraions of the problem of the best possible health for all of the people led the association to prepare a basic outline for continuing development and action. This is known as the National Health Program of the American Medical Association. The national health program is as follows:

### "THE NATIONAL HEALTH PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION

"1. Minimum standards of nutrition, housing, clothing, and recreation are fundamental to good health.

"2. Preventive medical services should be available to all and should be rendered through professionally competent health departments. Medical care to those unable to provide for themselves should be administered by local and private agencies with the aid of public funds when needed, preferably by a physician of the patient's choice.

"3. Adequate prenatal and maternity care should be made available to all mothers. Public funds when needed should be administered by local and private agencies.

"4. Every child should have proper attention, including scientific nutrition, immunization, and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child health centers administered locally with support by tax funds whenever the need can be shown.

"5. Health and diagnostic centers and hospitals necessary to community needs are preferably supplied by local agencies. When such facilities are unavailable, aid may be provided by Federal funds under a plan similar to the provisions of the Hill-Burton bill.

"6. Voluntary health insurance for hospitalization and medical care is approved, the principles of such insurance plans to be acceptable to the council on medical service and to authoritative bodies of State medical associations.

"7. Medical care, including hospitalization, to all veterans should be provided preferably by a physician of the veteran's choice, with payment through a plan agreed on between the State medical association and the Veterans' Administration.

"8. Research for the advancement of medical science, including a National Science Foundation, is endorsed.

"9. Services rendered by volunteer philanthropic health agencies should be encouraged.

"10. Widespread education in the field of health, and the widest possible dissemination of information regarding the prevention of disease and its treatment, are necessary functions of all departments of public health, medical associations, and school authorities."

It must be recognized that each one of these 10 avenues of approach to the problems of health maintenance and necessary treatment reaches directly into each community in the country and directly or indirectly to every individual in that community. The complexity of a problem involving so many factors obviously cannot be adequately dealt with by a single social measure. Likewise it must be admitted that each human being, as a mental and physical unit is a more complex structure than any social system which could be devised. So much is dependent upon the individual, his capacity, his education, his training, his sense of values, and his opportunities that any efforts made in his behalf must take into consideration all of these qualifications.

No social or legal measure can cover this field by any process of compulsion without in the end destroying the very qualities we seek to stimulate and develop in the individual. No social legislation containing those compulsions can be enacted without infringing upon the very basic qualities of American freedom. The only social measures compatible with the freedom of our American way of life is that providing opportunity to all and assistance where there is need. Administrators in high position will admit that governmental measures at the top too far removed from the local community and the individual are, even with the best intent, clumsy and inadequate or restrictive in their final application.

So much is dependent upon the education, the interest, and the voluntary effort of the individual that elevation of standards and program must be accomplished by local stimulation of effort and cooperation of these individual units in the community. Legislation cannot accomplish those ends. No pattern can be established at the national level that can be practicably applied to the varying conditions in each local community; nor can national regulations deal adequately and fairly in the determination of local need or the application of proper local remedies.

It is, therefore, evident that effective approach to the problem will rest upon the voluntary efforts awakened by stimulation of interest, and development of methods and assistance is demonstrated. It would seem that any legislation directed to this field would be largely concerned with providing financial assistance where need can be demonstrated and the setting up of safeguards to determine equable distribution of that assistance. Contributions from State or local levels should be required in proportion of financial ability. It will be necessary to leave to the local community the administration of local measures without introduction of bureaucratic controls or political interference.

Voluntary prepayment plans to provide for medical and hospital needs are growing very rapidly and exceed in public interest any proposals for compulsory Government methods. Dr. E. J. McCormick, chairman of the council on medical service of the American Medical Association, will present to the committee additional information concerning these voluntary plans.

Senate bill 545, introduced by Senator Taft, Senator Smith, Senator Ball, and Senator Donnell, more nearly approximates a legislative background for the development of a health program for the American peaple without destroying or restricting the objectives set forth in the broad national health program of the American Medical Association.

The house of delegates of the American Medical Association has repeatedly taken action recommending the consolidation of the health activities of the Federal Government, exclusive of the armed forces and the Veterans' Bureau, under a Department of Health, the head of that Department to be a Cabinet officer. It was further requested that the Cabinet officer shall be a competently trained doctor of medicine experienced in executive administration.

The Department of Health should not be subservient to any charitable, conservatory, or other governmental agency. The American Medical Association opposes the inclusion of the health activities of the Nation in a Department of Health, Education, and Security, for the reason that an adequate national health program such as is now in process of development by the American Medical Association could not attain the high objective sought, if it were combined in a Department of Welfare and Security. Evidence to this effect was presented in hearings before the Committee on Expenditures in the Executive Departments, United States Senate, Eightieth Congress. We have copies of the statement to that committee for inclusion in the record of these hearings, if you wish.

There is sufficient reason to maintain that the importance of the health activities is comparable to the importance of other departments and justifies the creation of a Department of Health of Cabinet rank. However, there is equal reason to believe that a national health agency without Cabinet rank could better serve the interest of the health of the Nation than the inclusion of the health acttvities with welfare or security, headed by a nonmedical Cabinet officer.

In this brief statement, it is impossible to discuss very completely the various features of Senate bill 545. However, certain provisions of the bill should be particularly pointed out, notably, the bringing together of all the scattered health activities into a national health agency headed by an outstanding physician; the determination of actual medical needs by requiring State surveys financed from Federal funds—this is a highly desirable feature; provisions of grant-in-aid to States also making some contribution for the extension of medical care to people unable to pay for it; the encouragement of voluntary prepayment plans; the provision for voluntary pay-roll deductions of Federal employees; periodic examinations of school children; and the provision for encouragement and grants-in-aid to certain types of research, properly directed.

These provisions of the bill should receive the approval of all those who are interested in a sensible approach to developing methods of extending aid rather than endeavoring to force upon the public a preconceived political pattern. It is noteworthy that no effort is made to establish criteria at the national level by which elegibility to low-income classification shall be determined in each local community. Obviously, the section of the country and living costs in proportion to income will have material bearing on that matter.

The appropriation of funds for the support of research in the prevention and control of cancer should be dependent as to the needs for continuation upon such cancer research as has been formerly under the direction of the Public Health Service. However, the situation might be changed if, as has been proposed, a new committee should be appointed by the President to furnish a central point for coordination of all major cancer research programs. The proposed committee would not be for the purpose of restricting properly organized or equipped effort, but rather to prevent the useless expenditures of funds beyond the capacity of facilities or available competent research personnel to carry on that work. Such a committee might well function under this National Health Agency and might require substantial funds. However, it might be determined that the cancer research conducted under the Public Health Service might be reasonably expended, but whatever is done should be in proper proportion and well coordinated with other cancer research. Those who are familiar with the research now being conducted and the capacity for expansion have advised of the useless waste of funds if appropriations exceed the amount that can properly be expended.

As to the total amount to be authorized annually for a period of 5 years for the development of the plans for improved health service, it must be recognized that there are no criteria by which the exact amount necessary for this work can be definitely determined. Various figures have been offered along with other legislative proposals. These estimates are frequently predicated upon very limited sampling, and often suggest that they are influenced by unwarranted enthusiasm for their particular proposal, so widely do they differ from any other reasonable statistical source. The provisions of this bill seem to identify it as being a well-planned and sensible approach to most needs which the whole Nation will recognize and approve as a necessary expenditure. The funds to be authorized under this legislation would obviously not be excessive and would vary as needs are determined or as local conditions make continuing aid to communities unnecessary. It is evident that the bill is not the promotion of a colossal plan of governmental regimentation at tremendous cost such as has been proposed.

Placing the responsibility for the administration of these plans at the community level tends to a more personalized community administration and a better integration of the activities under this plan with voluntary agencies and other local social developments. Especially is it important that the personal choice of physician be preserved and that nothing emanating from National Government levels be permitted to interfere with these local and personal medical aspects.

The provision for payments to physicians in the areas in which there would be insufficient income from professional services to attract a competent physician will require careful study. The study of these situations may properly be coordinated with the studying and planning for the establishment of facilities as authorized under the Hill-Burton law. Advisory councils designated by the governors of States may be helpful. Appointments to these positions should be made on the basis of competence and experience with sound medical guidance and not because of political preferences. Especially priorities given to certain areas in the development of facilities and establishment of plans probably will provoke more discussion than any other features of the administration of the act. However, if the personnel of the advisory council is carefully selected and has the respect and confidence of the public, this should not be unusually difficult. The advisory council has no authority other than advisory. The giving of some authority to the council might well be considered.

I do not wish to take the time of the committee in the presentation of technical data which would add nothing to the discussion and might tend to confuse rather than clarify the issues. The American Medical Association stands ready at any time to submit such detailed information as is available which the committee should desire or will provide more detailed reports of medical experience which might be helpful.

In summary, the bill seems to provide plans and means for the interweaving of Government and voluntary social and health agencies in such a manner as to permit the broadest variation in response to local needs. The American Medical Association is interested in the whole field of health and is desirous of bringing to every individual the benefits of the highest quality of medical care. It would seem that this bill would provide the legislative basis for meeting the needs of the lower-income groups without imposing a huge, expensive system of regimentation with its inevitable destruction of the quality of medical service. The medical profession will continue its efforts toward the development of its national health program and will oppose plans that are manifestly against the public interest.

Senator SMITH. Dr. McCormick, as I asked Dr. Sensenich, will you be good enough to make a brief statement for the record of your background and experience and qualifications as a witness in the matter?

## STATEMENT OF DR. EDWARD J. McCORMICK, CHAIRMAN OF THE COUNCIL ON MEDICAL SERVICE, AMERICAN MEDICAL ASSOCIATION

Dr. McCormick. I am Dr. Edward J. McCormick of Toledo, Ohio. I have been in the practice of medicine since 1915 and at the present time I am chairman of the Council on Medical Service of the American Medical Association.

Mr. Chairman, insofar as the bill under consideration at the present time——

Senator Donnell. Pardon me, Doctor, but would you be kind enough at the conclusion of the hearing or soon thereafter, at your convenience, to give us a list of the members of the Council on Medical Service, together with their addresses?

Dr. McCormick. That is included in some of the documents which I request be included in the records.

Senator Donnell. Very well.

Senator Smith. You may proceed.

Senator Donnell. May the record show at this point the list of members of the Council on Medical Service which appears on page 2 of the document, Voluntary Prepayment Medical Care Plan?

Senator Smith. Yes.

(The list of members of the Council on Medical Service of the American Medical Association is as follows:)

E. J. McCormick, M. D., Chairman, Toledo, Ohio.
H. H. Shoulders, M. D., Nashville, Tenn.
Roger I. Lee, M. D., Boston, Mass.
Louis H. Bauer, M. D. Hempstead, N. Y.
Alfred W. Adson, M. D., Rochester, Minn.
Walter B. Martin, M. D., Norfolk, Va.
Thomas A. McGoldrick, M. D., Brooklyn, N. Y.
James R. McVay, M. D., Kansas City, Mo.
Raymond L. Zech, M. D., Seattle, Wash.
George F. Lull, M. D., Chicago, Ill.
Joseph S. Lawrence, M. D., director, Washington office.
Thomas A. Hendricks, secretary, Chicago, Ill.

Dr. McCormick. Insofar as the bill presently under consideration suggests the——

Senator Donnell. May I interrupt you just one moment? You gentlemen are thoroughly familiar with the personnel here. Dr. Shoulders of Nashville, Tenn., was the president of the association last preceding the present president. Is that right?

Dr. McCormick. He is the president at the present time.

Senator Donnell. He is at this time?

Dr. McCormick. Yes.

Senator Donnell. There has been elected a gentleman who will succeed him?

Dr. McCormick. That is right.

Senator Donnell. So, Dr. Shoulders is still the president of the American Medical Association?

Dr. McCormick. That is right.

Senator Donnell. Go on.

Dr. McCormick. Senator, would you care to have me comment on other members of the council?

Senator Donnell. If you could, briefly, yes.

Dr. McCormick. Roger I. Lee is a well known internist in Boston, Mass., and is a past president of the American Medical Association.

Dr. Louis H. Bauer of Hempstead, N. Y., is an internist and at present a member of the board of trustees of the American Medical Association.

Dr. Alfred W. Adson of Rochester, Minn., is, perhaps, the leading neurosurgeon in the world and has been on the council since it was first elected.

Senator Donnell. Is he connected with the clinic?

Dr. McCormick. He is with the Mayo Clinic.

Dr. Walter B. Martin of Norfolk, Va., was elected to the council, I believe, about 2 years ago and is a very distinguished physician in his State.

Dr. Thomas A. McGoldrick of Brooklyn, N. Y., is likewise a very distinguished physician and has served on the council since its inception.

Dr. James R. McVay of Kansas City is a surgeon and has been very active in medical work in his community and in the communities surrounding his place of residence.

Dr. Raymond L. Zech of Seattle, Wash., is a surgeon who is greatly respected in his part of the country.

Dr. George F. Lull is the secretary of the American Medical Association, I think known to all members of the committee, having served in the Army of the United States for a great many years.

And the others listed are Dr. Joseph S. Lawrence who is in Washington and Mr. Thomas A. Hendricks, who are included in this list because of their activities having to do with the work of the council although they are not actually members of the council.

Senator Smith. I might say for the record here that we have the pleasure of knowing Dr. Lawrence and have seen him a number of times in connection with this legislation. He is a good friend of ours.

Doctor, may I ask you just this question before you continue? Is the statement you are making here a statement that might generally reflect the views of the entire council or is it your own personal view?

Dr. McCormick. It contains the views of the council, Senator.

Senator Smith. Thank you.

You may continue.

Dr. McCormick. The statement which I wish to make has to do with the voluntary prepayment medical care plans as they now exist.

The council is very familiar with these plans and in the bill which is being considered, the suggestion is made that services to the people when need is shown to be channeled through the existing prepayment medical plans.

The council on medical service was created by the house of delegates of the American Medical Association in 1943 to study and interpret existing and proposed programs pertaining to the economic, social or similar aspects of medical care; to suggest improvements in such programs; and to inform the medical profession of its studies. In its task the council has made every effort to be objective.

We have approached the problem of better health for the American people in proper perspective to the American way of living. Betterment of health is not a single problem. It is not merely a financial problem. It has many aspects and includes many fields of activity. The council first formulated a 14-point national health program which later was changed to the 10-point national health program, which has been mentioned by Dr. Sensenich, as a guide to improving the health of the American people. That program has been approved by the house of delegates of the American Medical Association. Our present program considers all factors affecting the health of the people: nutrition, clothing, recreation, preventive medicine, health departments, prenatal and maternity care, immunization and other children's services, facilities, research, education and methods of payment.

As physicians we are trained to study, to learn, to know. Improvements in diagnosis and treatment, in surgery, in drugs, are, as they have been for centuries, continually retested, rejected, restricted or extended according to their effect upon the health of the people. So too, in our council's work we have instituted studies so that we may learn and know before interpreting or recommending. Our studies have included the voluntary prepayment medical care plans, the cooperative voluntary industrial or commercial carrier plans, and compulsory insurance plans. They have also included studies of group practice, contract practice, private practice, clinic practice and other forms of medical organization. Much of the work has been directed to gathering data and general information.

Under title II, part A, of Senate bill 545, is a provision for surveys of medical care. The bill authorizes $3,000,000 to assist States in making a State-wide inventory of existing medical, hospital, and surgical care preparatory to the formulation of a plan for extending such care as contemplated by part B. This is commendable, since it assumes that the first step is the determination of the needs.

Scientific medical care is rendered only by physicians, although often with the aid of nurses, hospital facilities and dentists. That provision in title II, part A, line 22, page 14, requiring representation of nongovernmental groups or agencies concerned with the provision of services as well as those representing the users is also commendable.

The medical profession has been charged with a desire to maintain a monopoly in medical care programs. Physicians do have a monopoly in the sense that they are the only persons licensed to practice medicine and to provide such services. However, in financing and in the administration of medical programs the medical profession has recognized the assistance that can be supplied by persons experienced in administration and finance. We do insist on the profession's control over medical problems, and in our "standards of acceptance" for voluntary prepayment medical care plans we say:

> The medical profession should assume responsibility for the medical services included in the benefits; the medical profession is qualified legally and by education to accept responsibility for the character of the medical services rendered.

The part B of title II, line 16, page 16, of the bill authorizes funds to assist the States in providing general health, hospital, and medical services for families and individuals in the low income groups. One of the purposes for which these funds may be used is to—

> provide for the furnishing of such services to such families and individuals by means of payments (in the nature of premiums or partial premiums or reimbursement of expenses or otherwise) by the State, to any voluntary health, medical or hospital insurance fund, or other fund, operated not for profit, in behalf of those families and other individuals unable to pay for the whole cost of such services or insurance therefor.

The American Medical Association favors this method for financing medical and hospital services for the low income groups provided it is on a voluntary basis.

And you will note in the American Medical Association program we have always pointed out that we feel there should be some provision to show that need and help is necessary, by the individual States.

We have many reasons for saying voluntary as opposed to compulsory and will not enter into a discussion of the point here.

Many agencies exist through which a voluntary medical service program can be channelled. The State medical associations and county medical societies have for many years, assisted in providing for medical services for the low-income groups. The experiences of these organizations with the Federal Emergency Relief Administration plans, the Farm Security Administration plans, and local indigent medical care plans provide knowledge for administering such a program. All types, shapes, and sizes of plans were given experimental trial during the depression years. More recently, the Veterans' Administration plans, while not for the medically indigent, have provided medical societies with an opportunity to learn more of the problems involved in administering a medical care program.

Medical societies are organized in every State, the District of Columbia, and most of the counties in the United States. They include in their membership a majority of the practicing physicians. They are in a strategic position to determine local conditions, provide for local variances, and assess the value and quality of the services. Their participation in programs also places on them an obligation to maintain a high standard of medical practice.

While the American Medical Association favors the method suggested in the bill for meeting the medical needs of low income groups, it questions the feasibility of a "State-wide program" as mentioned in No. 4 of part A, section 712 (a) page 18, line 4, particularly if the program includes all medical services—unless this State-wide program provides for local differences in need, in utilization, etc. This necessity for considering local conditions is brought out in a study of indigent care programs made by the bureau of medical economics of the American Medical Association. This study points out that only 20 of the 48 States reported successful operation of a State-wide program under the Federal Emergency Relief Administration. The report states:

> The observation already suggested is confirmed that no Nation-wide plan of supplying such a personal service as medical care can be satisfactory. To this may now be added the further observation that it is doubtful if State-wide plans are practicable in a majority of the States. There are only 20 States in which the plan can be termed "successful", even with a liberal use of the word.

At present some 38 State-wide Veterans' Administration home town medical care programs and 91 voluntary prepayment medical care plans are functioning. This seems to contradict the above statements, but there is an explanation and it lies in the scope of services offered by the plans.

The Federal Emergency Relief Administration plans offered general medical care, including home and office calls, to recipients. The Veterans' Administration and most of the State-wide prepayment plans are offering a limited program. Early experiments with plans, other than in Washington and Oregon, showed clearly that the general public preferred a medium priced partial coverage plan, just as experience of auto collision insurance has shown that the car owners prefer a $25 or $50 deductible policy.

Senator Smith. That implies that a limited plan might be subject to State-wide administration, whereas you think a complete plan would have its difficulties? Is that the point?

Dr. McCormick. Certainly, depending upon the location which might happen to be under consideration.

Those State-wide prepayment plans which do offer a full coverage to subscribers, notably the Washington and Oregon plans, are so constituted as to provide for local—county or area—variation in people, customs, needs, fees, and so forth.

I think, Senator, that answers your question.

Senator Smith. Yes.

Dr. McCormick. This is true also in the actual administration of many of the Veterans' Administration programs previously mentioned. In other words, needs vary in different localities and plans are flexible to meet those local needs.

Prepayment medical care plans have been successful on both State-wide and local bases. They have also been successful with both the full coverage and the limited coverage programs. Most of the plans are so organized as to operate in any of the above categories. Where only local plans exist, they are usually so coordinated as to provide a collective State-wide program.

Through the surveys of medical care provided by the bill, decision might well be made, on a local basis, as to the all-inclusiveness or comprehensiveness of any given program; this, in turn, might well be a determining factor as to whether or not there should be a State-wide, a local plan, or an area plan.

Prepayment plans, as well as medical societies, have worked with governmental agencies in the provision of care for special categories and groups. A number of the Veterans' Administration programs already mentioned function directly through prepayment medical care plans.

This is true in California; it is true in Michigan; it is true in Ohio and I believe it is true in Kansas and several other States.

In at least one State the medical services of the old-age pensioners, and other special groups are channeled through prepayment medical care plans. The statutes under which many of the plans operate specifically provided that contracts be made with the various governmental and nongovernmental organizations and units for the provision of medical care either on the basis of contribution (that is, subscription rate or premium payment), or lump sum for all members of the group involved or on the basis of cost plus a fixed fee. The prepayment plans can cooperate under any or all types of these programs.

Much has been said to belittle the scope of the voluntary prepayment medical care plans. Yet the growth in this movement has been phenomenal. In 1942, some 15 voluntary prepayment medical care plans were listed as approved by medical societies and/or the Blue Cross. At present, just a little over 5 years later, the council's directory lists 91 plans. However, since the Oregon and Washington plans are usually counted as 2 State-wide plans the quotable figure becomes 64. Not only has the number of plans grown rapidly in the past few years, but their expansion throughout the United States is even more encouraging. The 15 plans listed in 1942 were operating in 10 States while plans have now been organized in 37 States and the District of Columbia and are in the process of organization in 10 additional States.

The growth in the number of medical plans has paralleled that of Blue Cross plans. Slightly more than 8 years have been required for the organization of 64 medical plans while in the first 8 years of Blue Cross 69 plans developed.

Again, as with enrollment, the medical plans expansion throughout the country is comparable to that of Blue Cross. In the 8 years of the medical-plan movement, plans have been begun in 35 States which, when added to the early Washington and Oregon plans, make 37 States.

In 13 of the 37 States with plans, more than one prepayment plan has developed. The effect of local conditions on this development is particularly indicated by the 23 plans in the State of Washington, the 8 plans in the State of West Virginia, the 6 plans in New York, and the 6 plans in Oregon.

Enrollment in the prepayment plans has increased rapidly in the past 2 years. The reported enrollment in December 31, 1944, was 1,500,000; on December 31, 1945, 2,845,000; while on December 31, 1946, it was approximately 5,000,000. Since the big growth in the number of plans has taken place during the past 2 years, it is reasonable to assume that growth of enrollment is just begining. Eighteen of the plans in operation a year or more on December 31, 1946, reported an increase of 100 percent. The highest increase was 1,110.9 percent with seven others reporting over 200 percent. Whereas we could point to only one really large plan a year ago, we can point today to five plans with more than 300,000 subscribers and six additional plans with over 100,000 subscribers.

Three general types of plans prevail at present. These are cash indemnity plans, service plans, and combinations of the two forms. Using 64 as the total number of plans now organized, the breakdown as to type is: 31 indemnity, 28 combination, and 6 service. Any definite trend toward any specific form of plan is not yet apparent.

During 1946 and the first part of 1947, 20 plans were organized. Of these, 7 were indemnity, 11 combination, and 2 service. Primarily, the determination as to the type of plan rests on the needs and desires of the community in the area in which it is organized. The people of our country, according to available evidence, recognize the desirability of prepayment plans for medical care. Many individual citizens still need to be convinced. This means education, as to the amount of personal funds which the worker will transfer from nonessential services or goods to protection against the cost of illness. Actually, the combination type of plan acts as a service plan for those persons in the low-income group, so that more than half of the organized plans do operate to protect those in the low-income group from excessive charges.

Casual observation might suggest that those plans which offer full coverage are preferable; yet, realization of the tremendous number of problems involved in controlling the abuses on home and office demands for physicians (abuses which would be vastly increased in a compulsory plan) and realization, too, that most workers require help only for the serious illnesses makes evidence the desirability that full-coverage programs await further experience with plans involving less difficulties. Physicians, who have had experience in the illogical and unnecessary demands that can be made upon time by those who abuse the plans, realize that any general program of this type would be imposible to establish with a good quality of medical care.

Combination plans, as was previously mentioned, are a protection for those in the low-income groups against excessive charges. These plans provide this protection through utilization of income limits to determine which subscribers are eligible to benefits without additional charges. Those below the specified income limits receive the benefits in full; those above the specified income limits may be charged additionally. Income limits in these plans vary from $1,500 for a single subscriber to $5,000 for a family. Although many variations are used, the most common seems to be $2,000 for a single subscriber and $3,000 for a family. Actually, the importance to the population as a whole of this agreement on the part of physicians to furnish services to a particular income group for a specified fee is overemphasized. Over-all studies of existing charges in relation to patients' income actually show that the income-limit theory is closely adhered to by the profession even in their private practices. Yet, the idea of income limits does serve a purpose in protecting individuals against unscrupulous practitioners, and, obviously, it is in the charge made by the unscrupulous physician that causes much of the furor concerning the exorbitant cost of medical service. Any proposal must differentiate clearly between medical services as provided by physicians and the over-all health services which include hospital care, drugs and medication, nonphysician services, and so forth, in discussion of this problem.

Basic issues everywhere—

It has been said—

> fall into the same pattern—all turning on the contest between those who seek security even if they have to give up freedom and those who think that in the long run the security of the individual will only be possible if freedom is retained.

Benjamin Franklin said:

> They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety.

George Washington wrote:

> He who seeks security through surrender of liberty loses both.

The American people prefer not to be coerced. You can reason them into performing in their own way almost any miracle—even winning two world wars. Skeptics have said that voluntary plans for medical care did not succeed in Europe and evolved inevitably into compulsory plans. There appears to be some evidence that democracy also is disappearing in Europe.

We need not model our provision of health care for the American people on any failing technique based on European methods of dictatorship and compulsion; we can find a voluntary way compatible with true American democracy.

Just a few weeks ago Winston Churchill said:

> In my experience of large enterprises, it is often a mistake to try to settle everything at once.

With suitable cooperation from a Government that wishes to find an answer to a problem rather than to enslave a profession, a technique will evolve that will provide to every American a high quality of medical care.

If it meets with the approval of your committee, I would like to present the up-to-date 1947 revised edition of Voluntary Prepayment Medical Care Plans, which gives you all the information.

Senator SMITH. Do you desire to include this booklet of charts?

Dr. McCORMICK. Yes, if it meets with the approval of your committee.

Senator SMITH. In looking over your document entitled "Voluntary Prepayment Medical Care Plans, Charts and Graphs," it appears to me to be very valuable, and it indicates especially the growth of the plan.

We would like very much to have that included.

(The document entitled "Voluntary Prepayment Medical Care Plans, Charts and Graphs" is as follows:)

## VOLUNTARY PREPAYMENT MEDICAL CARE PLANS, CHARTS AND GRAPHS—1947

### COUNCIL ON MEDICAL SERVICE, AMERICAN MEDICAL ASSOCIATION

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Roger I. Lee, M. D., Boston, Mass.
Louis H. Bauer, M. D., Hempstead, N. Y.
Alfred W. Adson, M. D., Rochester, Minn.
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George F. Lull, M. D., Chicago, Ill.
Joseph S. Lawrence, M. D., director, Washington office.
Thomas A. Hendricks, secretary, Chicago, Ill.

This pamphlet is published by the Council on Medical Service of the American Medical Association to supplement the council's exhibit at the association's annual meeting held in Atlantic City, June 9–13, 1947.

The council will be glad to supply further information on the voluntary prepayment medical care plan movement. Such information will be prepared for you to use in talks, articles, books, or simply for personal purposes. Inquiries should be directed to: Council on Medical Service, American Medical Association, 535 N. Dearborn St., Chicago 10, Ill.

Prepared by George W. Cooley, and Howard O. Brower.

### TREND TOWARD NATION-WIDE PREPAYMENT

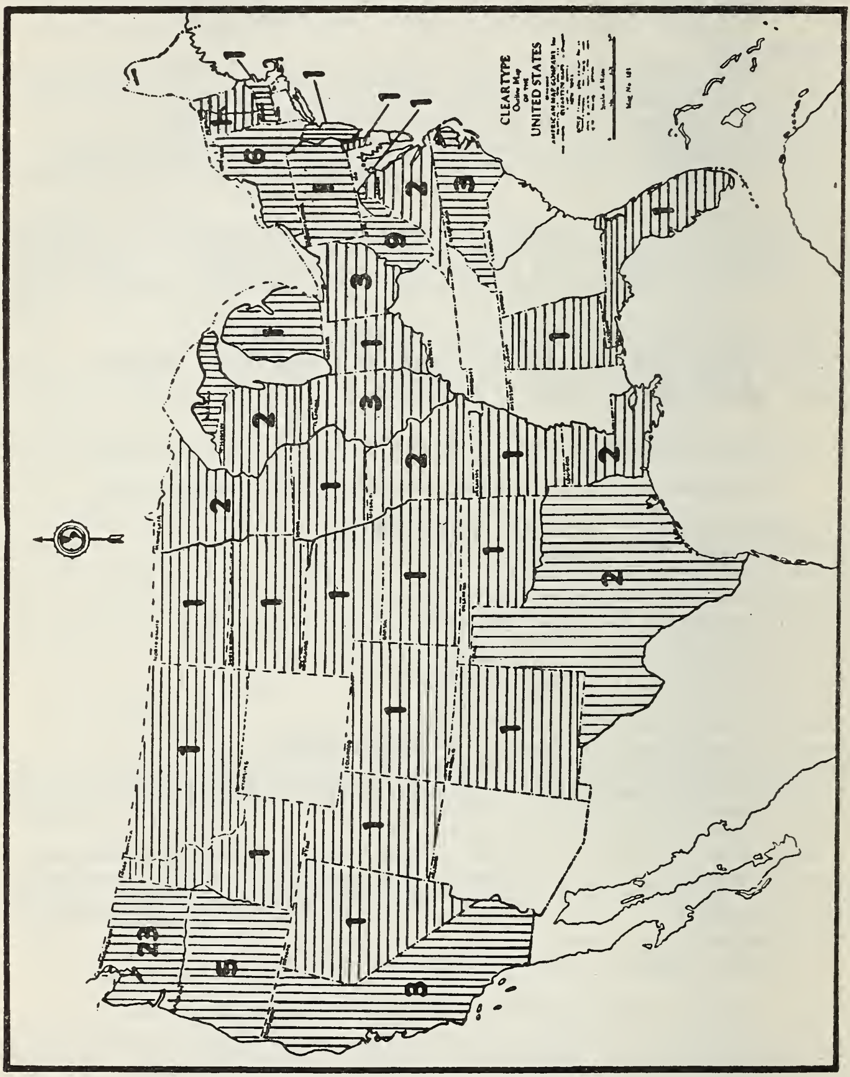
The map on the next page shows a definite trend toward the availability of Nation-wide voluntary prepayment medical care plant facilties. The rapid increase in the number of States having vountary prepayment medical care plans during the past 5 years exceeds the expectations of many who pioneered in the early plans.

The States marked with vertical lines are those in which prepayment medical care plans were organized up to and including 1942. Following the method of counting 64 plans (Washington and Oregon as each having one State-wide plan), 12 States had 15 plans up to and including 1942.

The horizontal lines depict those States in which voluntary prepayment medical care plans have been organized since 1942. Up to the present time there are now 64 plans in 37 States and the District of Columbia.

Most of the States shown in blank have plans in varying stages of development or have committees working on the development of voluntary prepayment medical care programs.

The rapid and general tendency of the various States and local medical societies throughout the country to promote and to continue to foster these programs is not only a tribute to those who pioneered in the prepayment field but also shows a definite trend toward making voluntary prepayment medical care plan facilities available on a Nation-wide basis.



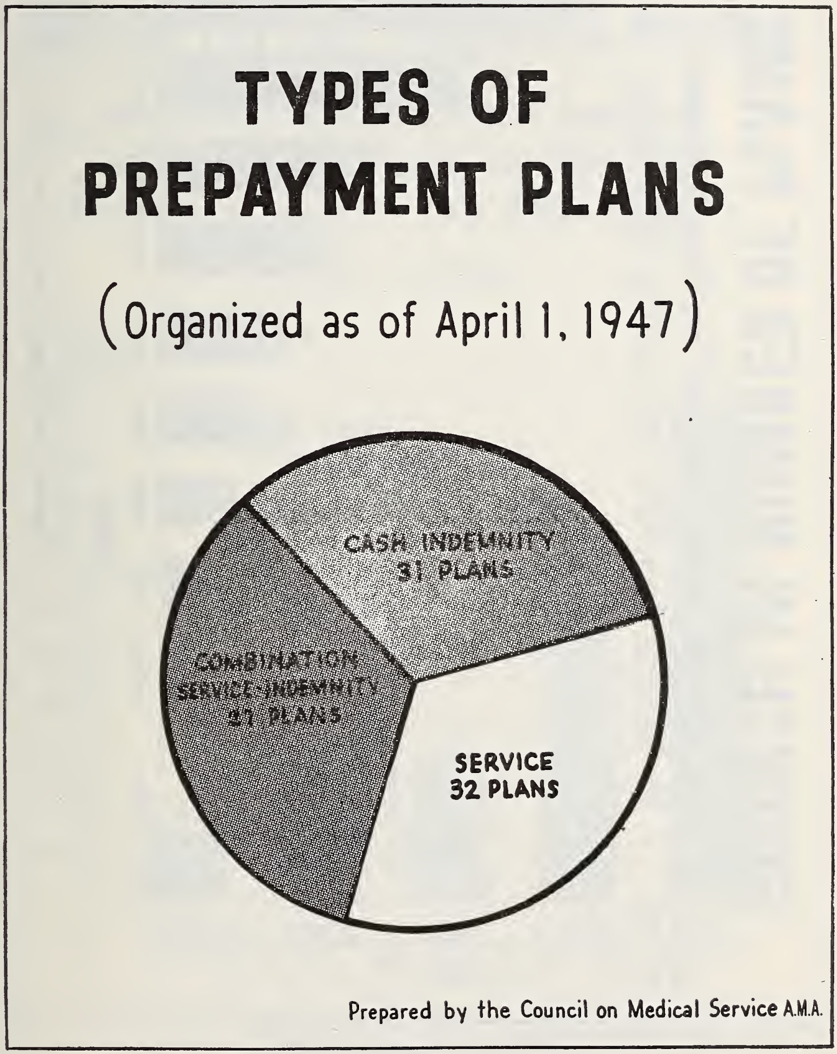
### TYPES OF PREPAYMENT PLANS

Generally speaking, there are three types of plans utilized in accomplishing voluntary prepaid medical care. These types are:

1. Service.
2. Indemnity.
3. Combination.

There are many variations and adaptations of the three main types. At the time this chart was prepared, the distribution as to types was about equal. In preparing this chart, separate identity was given the local plans in Washington and Oregon.

Service plans are those in which the subscribers are guaranteed certain surgical and/or medical services, when needed, without additional cost to the subscriber or dependent.



TYPES OF PREPAYMENT PLANS

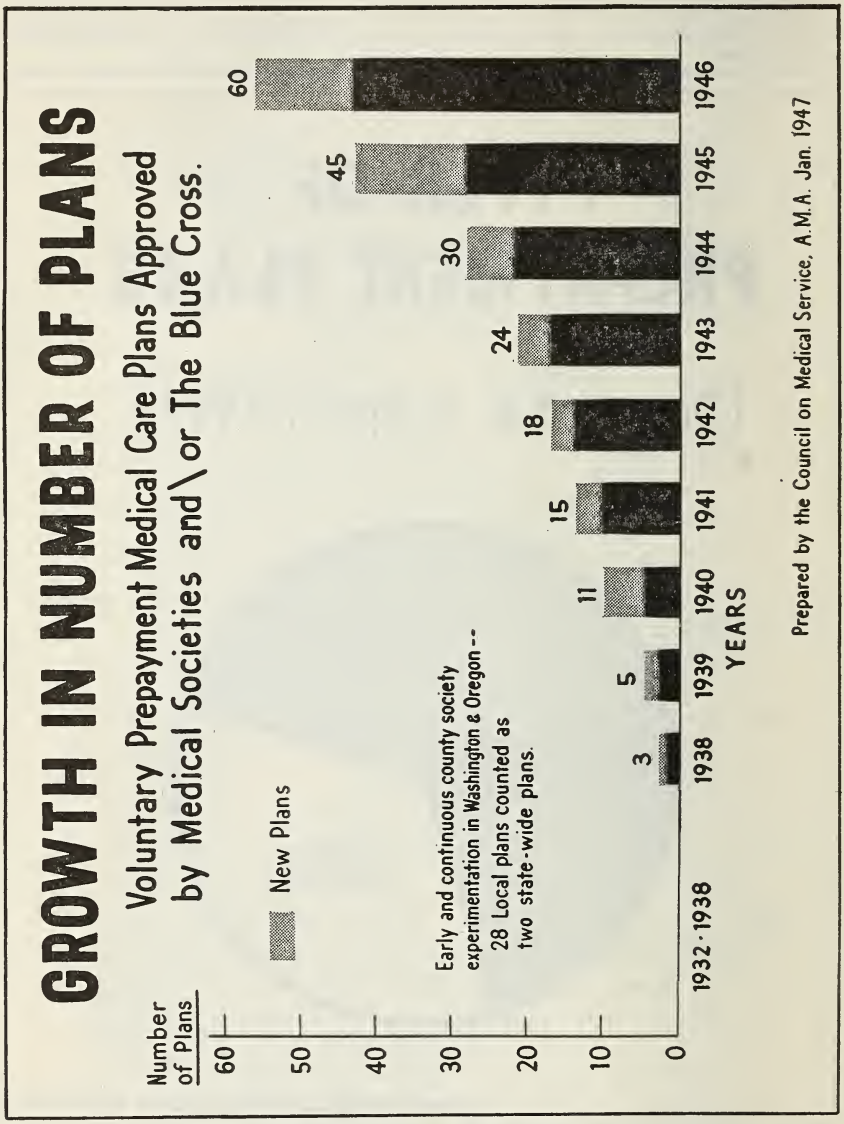
(Organized as of April 1, 1947)

Prepared by the Council on Medical Service A.M.A.

The indemnity type of plan provides benefits in terms of money as set forth in a predetermined "schedule of indemnities." Such benefits are then applied as credits toward the total cost of the care that has been rendered.

The joint use of both of these two methods of providing benefits is referred to as a combination type of plan. In this type, subscribers having incomes below a stated amount are guaranteed service benefits. In the case of a subscriber whose income exceeds this amount, the benefits in the "schedule of indemnities" apply as a credit toward the total cost for the medical care rendered.

Physicians participating in the service and combination type plans have contributed a great deal to the pioneering in the voluntary prepayment medical care plan movement. These physicians have aided materially in guaranteeing financial soundness to these plans and have brought much financial relief to those in the middle- and low-income groups who have taken advantage of these facilities.



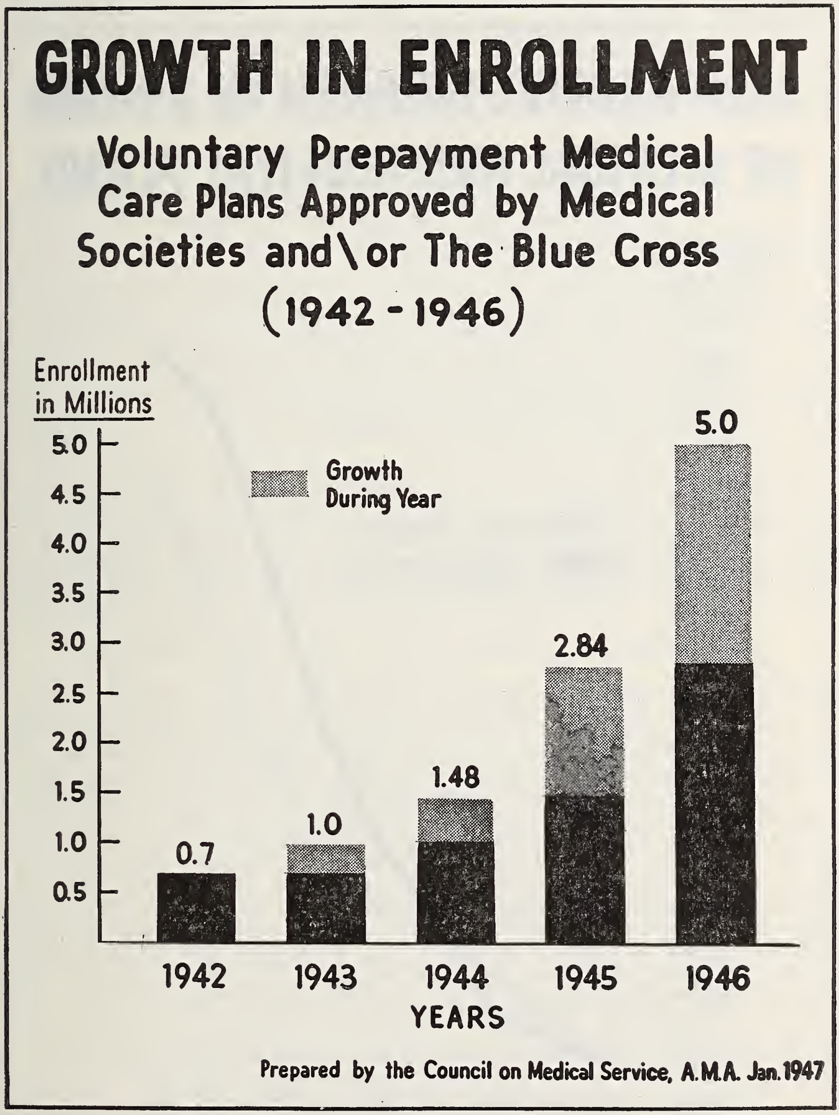
GROWTH IN NUMBER OF PLANS

The growth in the number of voluntary prepayment medical care plans has been rapid in recent years.

In the accompanying chart, the number is indicated as 60. In the brochure entitled "Voluntary Prepayment Medical Care Plan" it is stated that there are 64 plans. The reason for the difference is that this chart was prepared as of January 1947 and other references in the brochure included plans organized after that date up to and including the time of its publication.

In this chart the local plans in Washington and Oregon are grouped so as to report one State-wide plan in each State.

Very little large-scale development was evident in the years prior to 1940. Up to 1938 this movement was confined to the Northwest. When the movement did reach beyond the Northwest, it spread simultaneously in several parts of the country at one time. One new plan was organized in 1938. Two were organized in 1939. Six new plans came into existence in 1940; 4 in 1941; 3 in 1942; 6 in each of the years 1943 and 1944, and 15 each during 1945 and 1946.



GROWTH IN ENROLLMENT

Voluntary Prepayment Medical Care Plans Approved by Medical Societies and\or The Blue Cross (1942 - 1946)

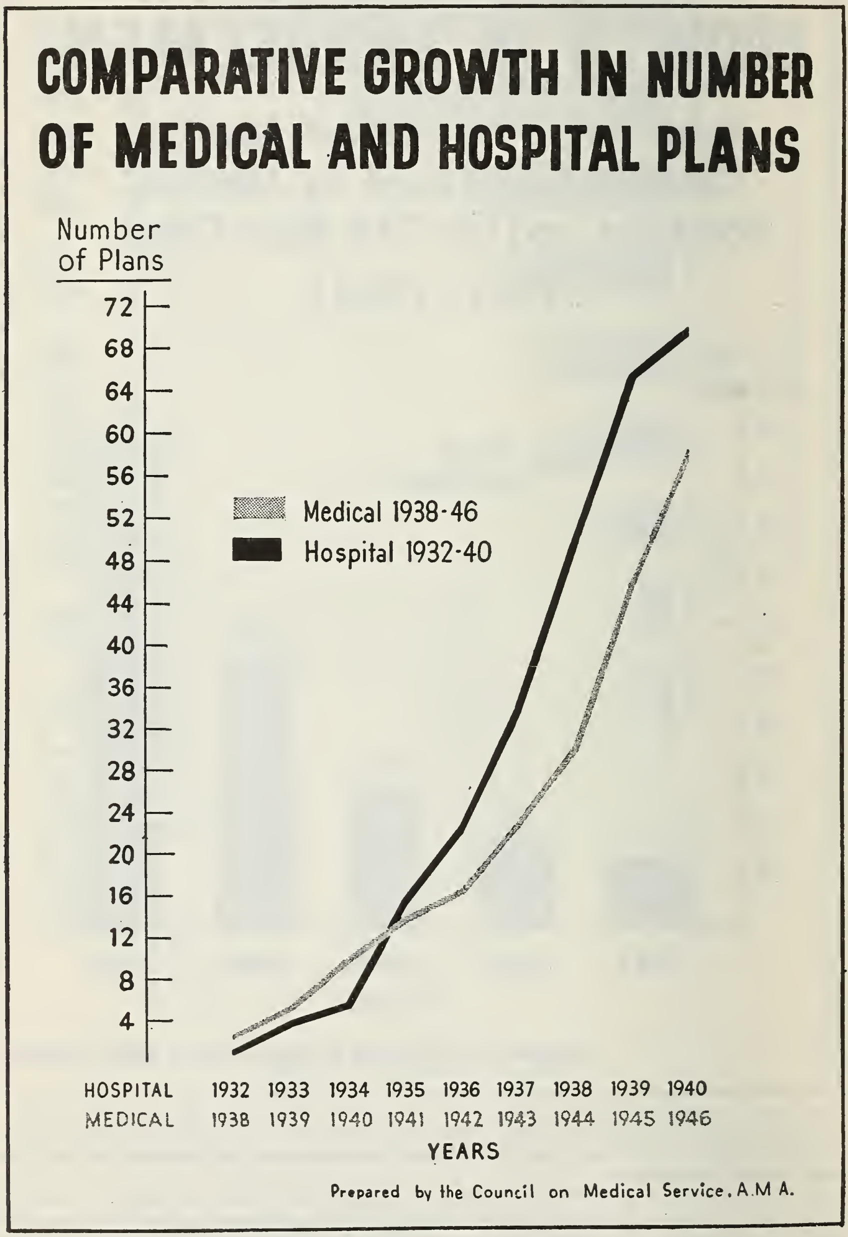
Prepared by the Council on Medical Service, A.M.A. Jan. 1947

The study in this graph includes those plans which were organized, sponsored, or approved by medical societies as well as those which were developed by various local Blue Cross plans.

During the past several years, many plans have been organized by other interests. In some instances, these interests have expressed a desire to amend their organizations in order to come within the standards acceptable to the medical profession. In view of this the council is extending its studies of prepayment programs to include those plans not now approved by medical societies.

### GROWTH IN ENROLLMENT

Shortly after the beginning of the present decade the movement became more widespread. The growth in enrollment was not quite as rapid in the early stages as was the growth in number of plans. This, however, is due to the many organizational details that have to be completed before any large-scale enrollment can be undertaken.



Prepared by the Council on Medical Service, A.M.A.

At the end of 1942, 700,000 people were enrolled in voluntary prepayment medical care plans sponsored or approved by the medical profession and/or local Blue Cross plans. This number increased to 1,000,000 during 1943. Almost 1,500,000 subscribers and dependents were enrolled in these programs by the end of 1944. This figure increased in 1945 to 2,840,000 and again to 5,000,000 by the end of 1946.

This continuous increase in enrollment and in the number of voluntary prepayment medical care plans is proof of public acceptance of the idea of preplanning and budgeting some of the costs of illness, injury, and disability.

It is also interesting to note that during this same period (1942–46) total premiums paid for voluntary accident and health insurance in the United States increased from slightly less than $350,000,000 in 1942 to over $680,000,000 in 1946.

### COMPARATIVE GROWTH IN NUMBER OF MEDICAL AND HOSPITAL PLANS

The growth in the number of voluntary prepayment medical care plans compares very favorably with that for the number of hospital plans.

Due to the fact that voluntary prepayment plans providing hospital care came into existence some 6 years prior to those providing medical care, two separate 8-year periods are necessary for comparing their relative growth.

In the accompanying chart the years 1932 to 1940 are used as the base period in the hospital prepayment field, and the years 1938 to 1946 are used as the base period in the development of voluntary prepayment medical care plans.

The black line shows the growth in the number of hospital plans while the gray line indicates the growth in the number of voluntary prepayment medical care plans. In this chart, the local and State plans in each of the States of Washington and Oregon are grouped to report one State-wide plan for each State.

Perhaps the medical care plan movement progress is better than portrayed. Hospital services are far fewer in number than medical or surgical services. Then, too, hospitals are institutions and can be contracted with as such.

On the other hand doctors of medicine are individuals and perform a highly individualistic type of professional service. The organizational and administrative problems confronting voluntary prepayment medical care plans far exceed those of plans which are limited to providing hospital care.

### COMPARATIVE EXPANSION BY STATES OF MEDICAL AND HOSPITAL PLANS

Many critics of voluntary prepayment medical care plans have commented that the number of States having such plans did not compare favorably with the number of States having hospital care—or Blue Cross plans.

As stated in the description of the previous chart, two sets of base periods are necessary to obtain a true comparison. In the chart the same base periods are used as were used for the preceding graph showing the number of plans.

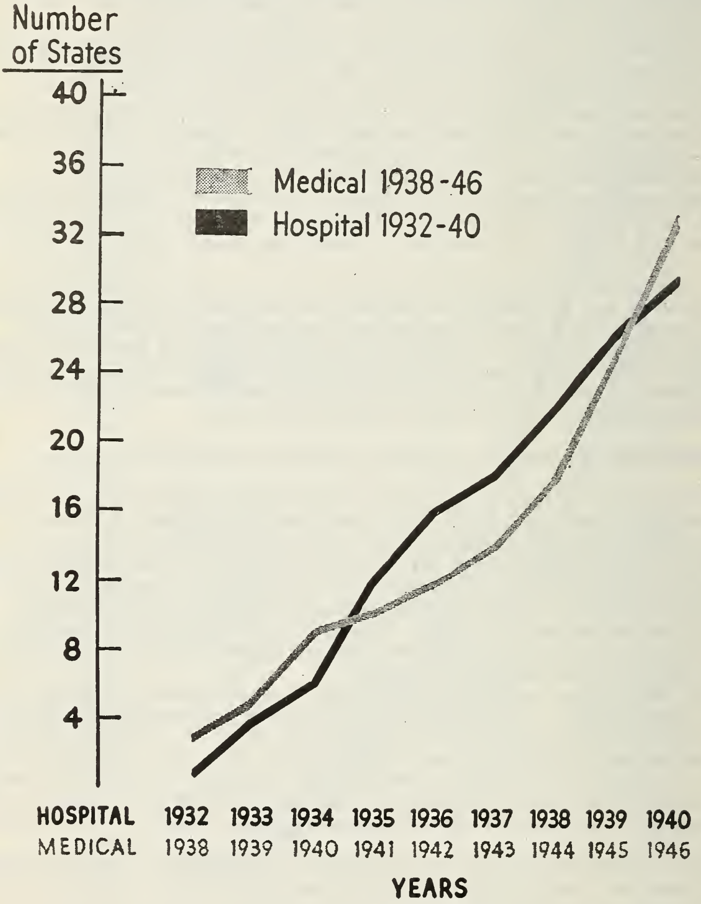
The gray line depicting the number of States having voluntary prepayment medical care plans compares very favorably with the black line denoting the number of States having hospital care plans.

In several States, the medical profession has sought special enabling legislation which would permit the formation of voluntary prepayment medical care plans. Several enabling acts were successfully enacted. In a number of States, attempts to get such legislation were unsuccessful and, in a few, the original bills were so amended before final passage as to make their provisions unworkable. In some of these latter instances, the medical profession organized insurance companies to accomplish the purposes originally sought in the enabling legislation.

In still other instances State and local medical societies have made agreements for certain surgical and medical benefits to be written by private insurance companies.

Thus, the medical profession in cooperation with other agencies has provided different methods of making voluntary prepayment medical care available to the people.

# COMPARATIVE EXPANSION BY STATES OF MEDICAL AND HOSPITAL PLANS



Prepared by the Council on Medical Service, A.M.A.

## PREPAYMENT PLAN CLAIM EXPERIENCE

This chart shows the portion of premium income of each of 32 representative voluntary prepayment medical care plans which was returned to the subscribers in the form of medical benefits or medical services during the year 1946.

Directly below the number assigned to each plan is indicated the year in which the plan was organized.

These 32 representative plans were taken at random. The portion of the premium income returned in the form of benefits or services ranges from 40.4 percent to a high of 92 percent. It should be borne in mind that plans returning a low percentage have reserved much of the income not returned during the year to pay beenfits to which the subscribers were entitled but had not been reported to the plans by the year end.

The combined income of all the plans represented by this chart amounted to approximately $32,000,000. Of this total amount 78.2 percent—or almost $25,000,000—was returned to the subscribers and their dependents in the form of medical benefits or services.

## PREPAYMENT PLAN ADMINISTRATIVE EXPENSE

One bar graph shows the percentage of premium income used for administrative expense by each of 32 representative voluntary prepayment plans. The same plans were used in preparing this schedule as were used to show the claim experience in the preceding chart. However, they are not in the same order.

Directly below the number of each plan, the year of plan organization in indicated.

The range from a low ratio of 7.9 percent to a high of 33.2 percent paid out for administration speaks well for the low total average when due consideration is given to the short period of time some of these plans have been in operation.

The total premium income for all the 32 plans represented here was approximately $32,000,000. Less than four and one-half million, or 13.7 percent of this total, was spent by these plans for administration during the calendar year 1946.

The council on medical service of the American Medical Association has formulated preliminary standards for voluntary prepayment medical care plans. One of these is that the plan should be organized and operated to provide the greatest benefits in medical care to the subscriber. Low cost of administration is in keeping with this standard.

## HOW THE VOLUNTARY PREPAYMENT PREMIUM DOLLAR IS SPENT

Previous bar graphs have indicated the portions of premium income used for claims and administration for each of 32 voluntary prepayment plans.

The figures used in the separate bar graphs are shown here in total for the calendar year 1946.

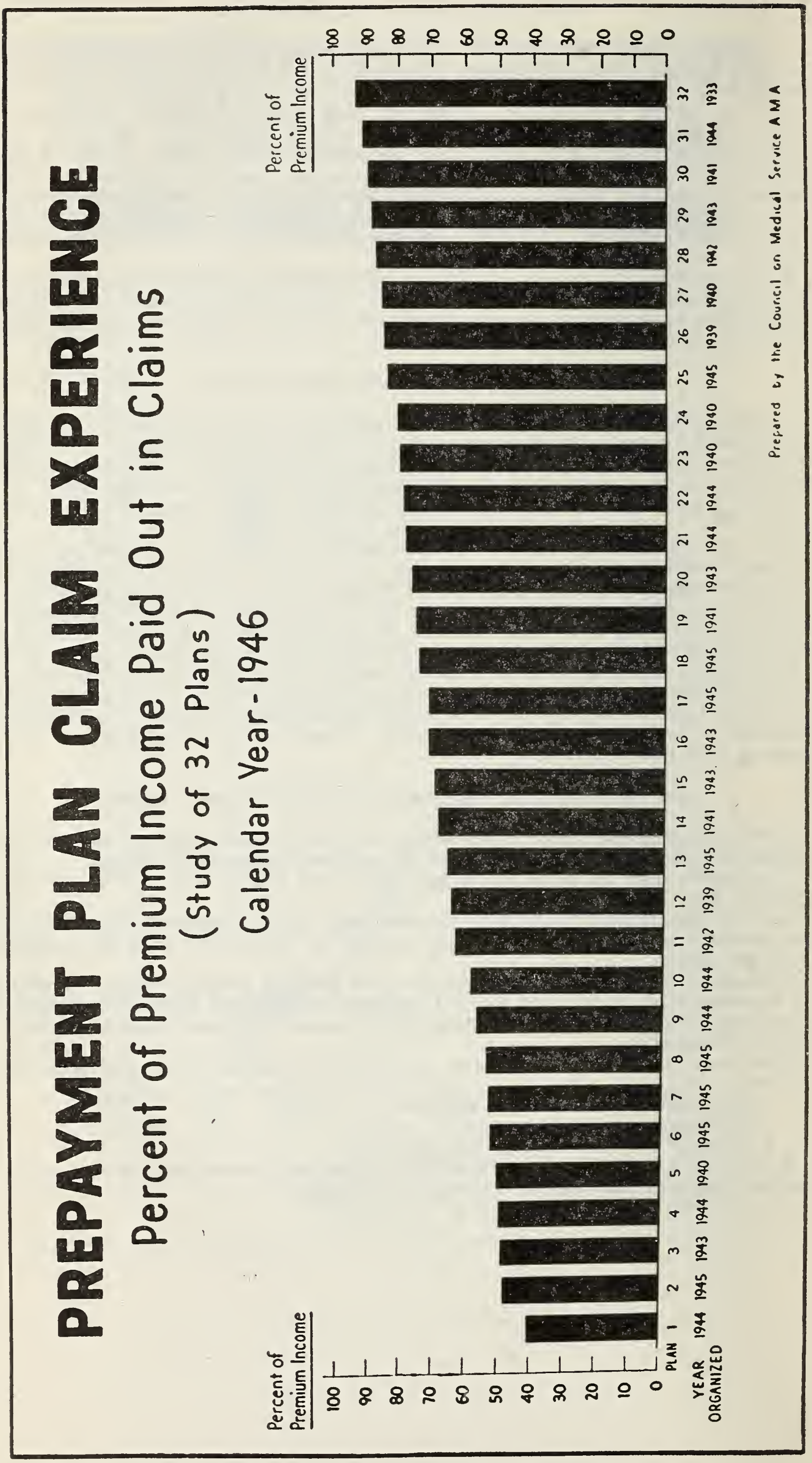
Many proponents of compulsory schemes have stated that subscribers do not get adequate returns under voluntary programs. This study does not support their contention.

This chart shows the portions of the total average premium dollar of these 32 representative plans used for (1) medical benefits and medical services to subscribers and dependents, (2) administration, and (3) miscellaneous expenditures and reserves.

Last year the average voluntary prepayment premium dollar was spent as follows:

78.2 percent for benefits and services.
13.7 percent for administration.
8.1 percent for reserves and miscellaneous.

As the plans, individually and collectively, gain more experience there is every reason to believe that improved operation will result.


PREPAYMENT PLAN CLAIM EXPERIENCE
Percent of Premium Income Paid Out in Claims
(Study of 32 Plans)
Calendar Year-1946
Percent of Premium Income
100
90
80
70
60
50
40
30
20
10
0
PLAN
YEAR ORGANIZED
1 1944
2 1945
3 1943
4 1944
5 1940
6 1945
7 1945
8 1945
9 1944
10 1944
11 1942
12 1939
13 1945
14 1941
15 1943
16 1943
17 1945
18 1945
19 1941
20 1943
21 1944
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23 1940
24 1940
25 1945
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28 1942
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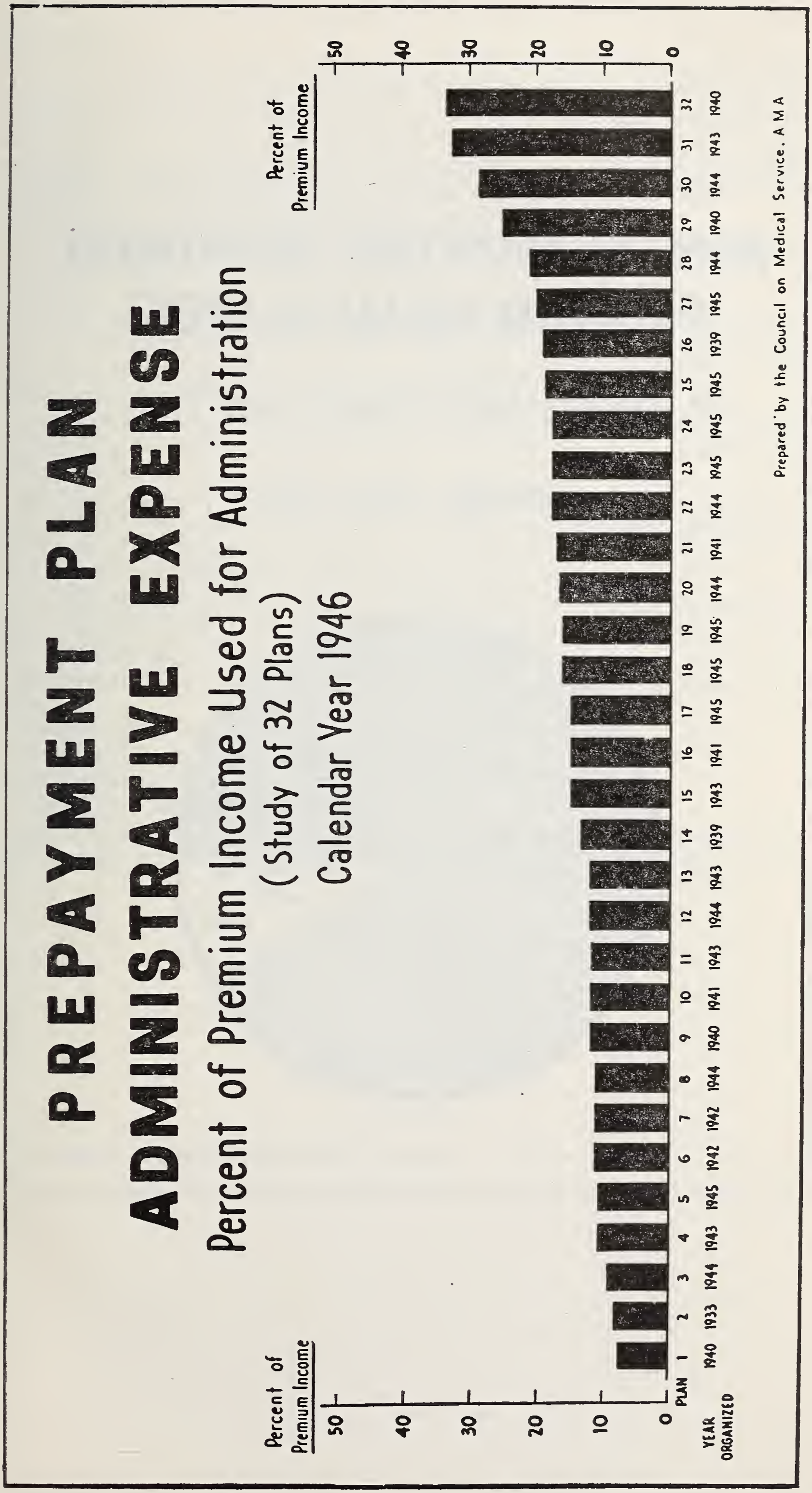
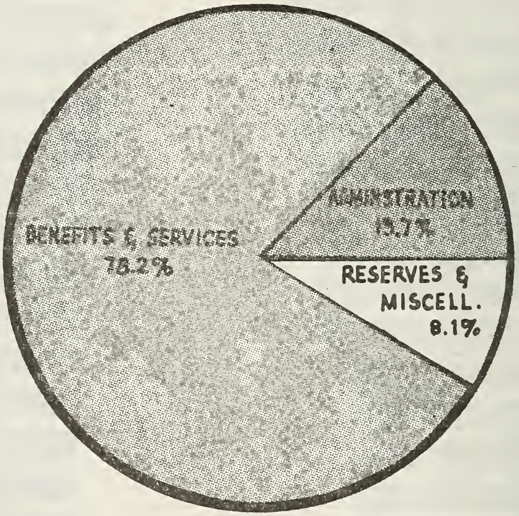
31 1944
32 1933
Prepared by the Council on Medical Service AMA


PREPAYMENT PLAN
ADMINISTRATIVE EXPENSE
Percent of Premium Income Used for Administration
(Study of 32 Plans)
Calendar Year 1946
Percent of Premium Income
50
40
30
20
10
0
PLAN
YEAR ORGANIZED
1 1940
2 1933
3 1944
4 1943
5 1945
6 1942
7 1942
8 1944
9 1940
10 1941
11 1943
12 1944
13 1943
14 1939
15 1943
16 1941
17 1945
18 1945
19 1945
20 1944
21 1941
22 1944
23 1945
24 1945
25 1945
26 1939
27 1945
28 1944
29 1940
30 1944
31 1943
32 1940
Percent of Premium Income
50
40
30
20
10
0
Prepared by the Council on Medical Service, A M A

# HOW THE VOLUNTARY PREPAYMENT PREMIUM DOLLAR IS SPENT

## 32 Representative Medical Care Plans

## Calendar Year 1946



Prepared by the Council on Medical Service, A.M.A.

Senator SMITH. Is there any special comment you desire to make on the record?

Dr. McCORMICK. I think, Senator, I have nothing to add to what has already been said by Dr. Sensenich except to say to you and to your committee that the council on medical service of the American Medical Association feels that the voluntary prepayment medical care plan movement has now developed to a point where it is possible, if the bill is passed, to channel the various efforts to help people in the low income groups through the prepayment medical care plans.

They are all sound and most of them are doing very well and improving and growing very rapidly.

Senator SMITH. Do you feel, Doctor, that the publicity that has surrounded these plans and the growth in the last couple of years—I notice from your report which I happened to read last night—that we can look forward to continuing expansion of these plans to cover more and more segments of our population?

Dr. McCORMICK. We anticipate there will be great growths during the coming year, not only in number of plans but in the number of enrollments.

Senator SMITH. And, you feel this type of plan to be particularly applicable to so-called white collar workers that Senator Murray, or I believe it was Senator Pepper, referred to as not being adequately covered, and suffering the most in the present situation?

Dr. McCORMICK. As a matter of fact, Senator, there is no question but that those people referred to can be covered at very much less expense than they could be in any other manner.

Senator SMITH. Senator Donnell, do you have any further questions?

Senator DONNELL. No.

Senator SMITH. Thank you very much.

This hearing is recessed until tomorrow at 9:30 o'clock.

Thank you very much.

(Whereupon at 12 noon the subcommittee adjourned pursuant to reconvening at 9:30 a. m. tomorrow, Thursday, May 22, 1947.)

# NATIONAL HEALTH PROGRAM

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## THURSDAY, MAY 22, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Smith, Donnell, Murray, and Pepper.

Senator Smith. The committee will please come to order. The hearing today will be devoted to the testimony of the New York Academy of Medicine group. The New York Academy of Medicine, I am advised, is a medical association of many years standing and with a very distinguished record, and I should like to state for the record in a preliminary way that for the past few years the academy has been making an intensive study of the whole matter of medicine and health in the United States in the changing world that we live in. A number of books dealing with this matter have been published, and I think for the record I shall put in the names of those books and their authors as part of the over-all survey that the New York Academy of Medicine has made of the subject. I will give that list of publications to the clerk and it will go into the record.

I am going to call as the first witness this morning Dr. George Baehr, who is president of the academy, and who will testify on S. 545, the bill that is before the committee, and I will ask Dr. Baehr to give us his views on that bill, his approach, and I will also be pleased to have him criticize it and tell the committee how the bill can be improved, or where he thinks anything should be taken out that is now in the bill. We will be very glad to hear from you at this time, Doctor.

First, let me ask you, Doctor, before you begin to testify, will you just give us a very brief biography, indicating your professional training and experience and your qualifications, as it were, as an expert witness in this matter?

## STATEMENT OF DR. GEORGE BAEHR, PRESIDENT, NEW YORK ACADEMY OF MEDICINE, NEW YORK, N. Y., ACCOMPANIED BY DR. IAGO GALDSTON, AND DR. HOWARD CRAIG, NEW YORK ACADEMY OF MEDICINE

Dr. Baehr. Mr. Chairman, I am a practicing physician. In addition to being president of the New York Academy of Medicine, I am clinical professor of medicine at Columbia University, chief of the first medical division and director of clinical research at the Mount

Sinai Hospital, New York, and consultant to a number of other hospitals in New York and New Jersey.

Senator Smith. Doctor, have you practiced in New York all your life; been identified with medicine in New York?

Dr. Baehr. I have.

Senator Smith. And you have made a study, not only of the hospital set-up in New York but of the general health problem and the way in which the doctors may be organized to help in this over-all health program?

Dr. Baehr. Yes; the improvement of medical care and public health has been my concern for a great many years, and for many years I have been a member of the public health council of the State of New York.

Senator Smith. Is my statement correct that you are president of the New York Academy at the moment?

Dr. Baehr. Yes, sir.

Senator Smith. And you have been for the past year?

Dr. Baehr. I have been for the last year and a half.

Senator Smith. Could you state just briefly, before you start your testimony, the over-all picture of the New York Academy of Medicine? As I understand it, it is not limited to New York City; it is an academy, an association of physicians that covers a large area in New York State. Will you give us a brief statement of the Academy of Medicine?

Dr. Baehr. The academy has been in existence just 100 years. Although its name identifies it with the city, its membership and its influence in the field of medicine and public health extend very widely throughout the country and even abroad. It is devoted to the improvement of medical education, the advancement of medical science, the promotion of public health. It maintains one of the largest medical libraries in the world.

Senator Donnell. How many volumes, Doctor?

Dr. Baehr. I think about 250,000 volumes. It is the second largest to the Surgeon General's library, and I believe it has seven times as many readers as the Surgeon General's library has. It does not concern itself with the economic interests of the physician, but devotes itself to public service, improvement of public health and medical education, and standards of medical practice.

Senator Smith. Is it a nonprofit organization?

Dr. Baehr. It is entirely nonprofit.

Senator Smith. Supported by the dues of members?

Dr. Baehr. No; the dues of the members defray only one-fifth of the budget. The rest of the budget comes from public contributions, from endowments that have been received from philanthropic foundations and other sources.

Senator Smith. What is the membership?

Dr. Baehr. All together, in all categories, of membership or fellowship, as we call it, there are about 2,400, of whom 1,800 are resident fellows.

(At this point, Senator Murray took a seat at the committee table.)

Senator Smith. Senator Murray, the witness is Dr. George Baehr, president of the New York Academy of Medicine. He was just telling us a little bit about the Academy of Medicine and its place in the over-all picture.

Senator MURRAY. I know the Doctor. He has been a very helpful witness in the past.

Dr. BAEHR. Of the 2,400 fellows of the academy, 1,800 are residents and the remainder are nonresident or in a research classification, the nonresident fellows residing throughout the country out to the west coast.

Senator SMITH. The members of your academy are likewise members of the American Medical Association? They are not separate associations?

Dr. BAEHR. Oh, no. They belong to the American Medical Association and to a variety of scientific professional organizations throughout the land.

Senator SMITH. Doctor, I mentioned in the opening, and I would like to have you develop it just a little bit further, that a few years ago, realizing the dangers in the world, with the state of war and everything, we felt it desirable to give a study to the over-all health proposition. I would like to have you just outline very briefly what the nature of that study was and how it was set up.

Dr. BAEHR. Four or five years ago, in appreciation of the urgent need for changes in medical practice that would bring medical services to the people more adequately and in accordance with modern medical standards, the academy organized a Committee on Medicine and the Changing Order, which was composed of lay as well as medical persons, and supported by three philanthropic foundations. It carried on its work intensively for a period of 3 or 4 years, and published 8 or 10 monographs on various aspects of the subject. These monographs provide the factual data upon which was finally based the book called "Medicine in the Changing Order," which contains the report and final recommendations of the Committee on Medicine and the Changing Order.

Senator SMITH. I have here, I think, Doctor, the book that you are referring to, entitled "Medicine in the Changing Order. Report of the New York Academy of Medicine Committee on Medicine and the Changing Order," and on the introductory pages here is a list of the publications that your committee studied, the New York Academy of Medicine Committee on Medicine and the Changing Order. Is that an accurate list?

Dr. BAEHR. Yes. There are one or two more volumes still to be issued.

Senator SMITH. It refers to two books here for early publication. Are those the extra ones you refer to?

Dr. BAEHR. Those are the extra ones.

Senator SMITH. Would it be proper—would I have the correct list of your studies if I inserted in the record this list of books appearing in this report?

Dr. BAEHR. Yes, sir.

Senator SMITH. And would I be correct as far as the membership of your committee is concerned if I had inserted in the record the names of those appearing on the next flyleaf, the list entitled "The New York Academy of Medicine Committee on Medicine and the Changing Order. Malcolm Goodridge, M. D., Chairman"?

Dr. BAEHR. That is the committee.

Senator SMITH. And below that is a list entitled "Program and Planning Committee. Malcolm Goodridge, M. D., Chairman. Iago Galdston, M. D., Secretary."

Dr. BAEHR. Quite right, Senator.

Senator SMITH. Without objection those lists will be inserted in the record, just to indicate the background of the committee that has been doing this work.

(The lists referred to follow:)

## Studies of the New York Academy of Medicine Committee on Medicine and the Changing Order

American Medical Practice in the Perspectives of a Century. By Bernhard J. Stern, Ph. D. 1945.

Government in Public Health. By Harry S. Mustard, M. D. 1945.

A Future for Preventive Medicine. By Edward J. Stieglitz, M. D. 1945.

Medicine in Industry. By Bernhard J. Stern, Ph. D. 1946.

Nursing and Nursing Education. By Agnes Gelinas, R. N. 1946.

Medical Services by Government: Local, State, and Federal. By Bernhard J. Stern, Ph. D. 1946.

Medical Education and the Changing Order. By Raymond B. Allen, M. D. 1946.

The American Hospital. By E. H. L. Corwin, Ph. D. 1946.

Dentistry: An Agency of Health Service. By Malcolm Wallace Carr, D. D. S. 1946.

Health Insurance in the United States. By Nathan Sinai, Dr. P. H.; Odin W. Anderson; and Melvin L. Dollar. 1946.

### FOR EARLY PUBLICATION

Medical Research. By Richard H. Shryock, Ph. D.

Medical Addenda: Related Essays on Medicine and the Changing Order.

## The New York Academy of Medicine Committee on Medicine and the Changing Order

Malcolm Goodridge, M. D., *Chairman*

Donald B. Aldrich, D. D.
Henry Aranow, M. D.
George Baehr, M. D.
David P. Barr, M. D.
Mrs. August Belmont
Robin C. Buerki, M. D.
Malcolm W. Carr, D. D. S.
Arthur F. Chace, M. D.
Henry Sloane Coffin, D. D.
Howard Craig, M. D.
Jean A. Curran, M. D.
Condict W. Cutler, Jr., M. D.
Mr. John W. Davis
Mr. Julius Emspack[1]
Katherine Faville, R. N.
Mr. Homer Folks
Mr. Walter S. Gifford
Edward S. Godfrey, Jr., M. D.
Alan Gregg, M. D.
William W. Herrick, M. D.[2]
Joseph C. Hinsey, Ph. D.
Mr. Franklin B. Kirkbride
Shepard Krech, M. D.
Henry E. Meleney, M. D.
James Alexander Miller, M. D
Harold R. Mixsell, M. D.
Claude W. Munger, M. D.
Bernard S. Oppenheimer, M. D.
Walter W. Palmer, M. D.
Mr. Louis Pink
Eugene H. Pool, M. D.
Robert E. Pound, M. D.
Tracy J. Putnam, M. D.
Willard C. Rappleye, M. D.
Paul Reznikoff, M. D.
Thomas M. Rivers, M. D.
Mary M. Roberts, R. N
Donal Sheehan, M. D.
Richard H. Shryock, Ph. D.
Wilson G. Smillie, M. D.
Ernest L. Stebbins, M. D.
William S. Tillett, M. D.
Edward Tolstoi, M. D.
J. Raymond Walsh, Ph. D.[3]
Grace Warman, R. N.
Herbert B. Wilcox, M. D.
Leo Wolman, Ph. D
I. Ogden Woodruff, M. D.

Iago Galdston, M. D., *Secretary*

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[1] Resigned June 27, 1946.
[2] Deceased.
[3] Resigned October 31, 1946.

### PROGRAM AND PLANNING COMMITTEE

Malcolm Goodridge, M. D., *Chairman*
Iago Galdston, M. D., *Secretary*

David P. Barr, M. D.
Mrs. August Belmont
Arthur F. Chace, M. D.
Jean A. Curran, M. D.
Mr. John W. Davis
Mr. Homer Folks
Alan Gregg, M. D.
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Herbert B. Wilcox, M. D
Leo Wolman, Ph. D.
I. Ogden Woodruff, M. D.

Senator SMITH. Now, Doctor, I think we are prepared to have you go ahead with your testimony, because there probably will be other questions come to us with regard to this important study made by the Academy.

Senator DONNELL. May I ask the Doctor if he has any objection to incorporating one sentence from this book "Medicine in the Changing Order," this sentence, referring to the dozen monographs to which you have referred in your testimony already:

> While these volumes were produced under the aegis of the committee, individual authors were given free rein in their preparation, restricted only as to length in order that all of them might conform to a common format.

In other words, I take it you were trying to get all phases of opinion, and ultimately you published "Medicine in the Changing Order" as a sort of digest?

Dr. BAEHR. Yes, sir.

Senator DONNELL. But you gave free rein and took all shades of opinion, and endeavored to afford ample opportunity for all varieties of opinion? Is that correct?

Dr. BAEHR. Yes, sir. In line with your inquiry, we did have the benefit of the assistance of persons of all types of belief, theories and experience, without regard to what they were.

Senator SMITH. In other words, you tried to approach the subject objectively, without any preconceived ideas, let the light fall where it would in arriving at your ultimate conclusions, which I take it, as far as the committee is concerned, are embodied in the book entitled "Medicine in the Changing Order"?

Dr. BAEHR. Senator, many of us differed in our opinions at the beginning of the study, and we came together gradually during the course of the study so that we could finally issue the statements which appear in that volume.

Senator SMITH. Thank you, Doctor. Will you proceed now with your testimony?

Dr. BAEHR. Senator, we wish to record our endorsement of S. 545 in principle and to indicate the desirability of certain amendments which we hold to be essential if the objectives of the bill are to be accomplished.

Section 2, paragraphs (b) and (c) state that the purpose of the bill is to make adequate health and medical services available to every individual in this country regardless of race or economic status through Federal consultative services and grants-in-aid to the States.

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[1] Deceased.

We have studied the bill carefully and find that these basic principles, and many of the details of the bill, are in conformity with the recently published recommendations of the Committee on Medicine and the Changing Order of the New York Academy of Medicine. On the other hand, the changes in the bill which we propose have not as yet been considered by the Council of the Academy and represent for the most part only the recommendations of its newly reorganized committee on Medicine and the Changing Order.

On the positive side, we strongly support liberty for each State to survey its own health and medical needs, with the aid of consultative services and financial assistance of the Federal Government, for the purpose of preparing a well-planned program which will meet the needs of the people of the State or the various needs of its political subdivisions. We are convinced that at this moment medical services cannot be created where they do not exist merely by the sudden enactment of a Federal law providing for compulsory medical insurance for all the people of this Nation, without any regard for the paramount question as to whether health and medical services actually exist at this time in all parts of our country or whether they could be created by a reorganization of existing medical facilities and services.

S. 545 acknowledges the complexity of the problem which confronts this country because of the great unevenness in the distribution of health and medical services in many parts of our land. By implication it also acknowledges that with prepayment for comprehensive medical and hospital care, come new problems of medical practice which are not easy to solve. When payment for medical care is made by a third party, an impersonal insurance carrier, a change occurs in the attitude of the patient, who no longer has to pay for each individual service, and of the physician who must render the service.

The New York Academy of Medicine is opposed to national compulsory medical insurance because at this time it would bring upon us insuperable difficulties in administration at the local level. The present forms of private medical practice, with separate fees for each service, cannot operate as the sole method under an insurance plan which provides comprehensive medical service. Abuses by patients and doctors cannot be controlled under such a system of payment and rapid deterioration of the present high standards of medical practice in this country cannot be prevented.

For this reason, we prefer a more gradual application and extension of prepayment for medical and hospital care as provided by S. 545. The essential virtue of S. 545, in contradistinction to the Wagner-Murray-Dingell bill, is that it will encourage the gradual development of local and State-wide medical insurance programs and avoid a Nation-wide compulsory program which would come upon us overnight like a cataclysm, when we are professionally and institutionally unprepared. S. 545 envisages an orderly adoption of medical care programs by States after careful surveys; and it thereby provides opportunities for the gradual organization of newer and better forms of medical practice to meet the new conditions created by the spreading adoption of the prepayment principle.

Our criticism of S. 545 is that its wording, section 711, page 16, line 19, permits the interpretation that it is primarily designed as a "charity" or "relief" measure. This should be corrected by stating specifically that the services are to be available to persons in the following categories:

1. The indigent, for whom the local, State and Federal Government must provide the entire cost;
2. Those whose low incomes permit only partial payment for comprehensive medical care; and
3. Those whose incomes are higher than category 2 but are inadequate to pay the entire cost for superior medical care.

It should be clearly stated that the object of section 711 is to assist the States to provide superior medical service at low cost through prepayment to all persons of low income in all three categories.

In section 711, page 16, the word "general"—end of line 17—should be replaced by the word "comprehensive." If the Federal Government were to provide grants-in-aid to the States for anything less than comprehensive medical services, that is, for limited coverage such as for medical and surgical services in hospitals and not for home and office care and diagnostic consulting services, it would violate the definition of medical services as defined in section 2, paragraphs b and c. Limited coverage which does not include home and office care and consulting and laboratory services for ambulatory patients omits most preventive services and therefore will not materially influence morbidity rates.

One of the most important omissions from S. 545 is the absence of any reference to medical standards. Neither the Administrator nor the Director of Medical Care Services is given authority to require the States to provide services which meet standards of performance to be established by a National Advisory Health and Medical Council or by the National Medical Care Council. This is a serious omission. Without minimal Federal standards and the right of the Administrator and the Director to inspect and determine whether such standards have been met by the States receiving Federal grants-in-aid, the bill could result in lowering the level of medical practice. Also, no provision is made to assist the States in improving and extending medical education and post-graduate medical training.

Somewhere in section 711, or elsewhere in this bill, provision should be made for grants-in-aid to States and to its political subdivisions for experiments in newer technics in providing superior medical services under a prepayment plan, such as group medical practice. Such medical groups can accept capitation payments for their services and can be organized so as to provide complete medical and preventive services. However, experience has demonstrated that they cannot as a rule get started without some financial assistance or a loan during the stage of organization.

Also voluntary medical insurance plans require subsidies or loans during their formative periods and provision should be made specifically for this purpose.

I should now like to make a few more detailed criticisms.

Section 101, National Health Administrator: In addition to being a doctor of medicine licensed to practice in one or more of the States, who is outstanding in medicine, we regard it as essential that the person to be elected to administer the National Health Agency should, of necessity, have previously demonstrated administrative ability of a high order. We also assume that the term "field of medicine," page 3, line 16, includes any of the clinical and scientific branches of medicine and surgery as well as the field of medical education, medical research and public health.

The functions of the Administrator are not well enough defined under section 101 or under any other section of this bill. In section 102, the functions of the various divisions of the National Health Agency are described but in section 104, they are allocated to autonomous subdivisions.

Except for certain fiscal responsibilities, sections 105 and 106, and the requirement under section 108 that the Administrator make a study of the Agency and report his findings and recommendations to the Congress within 6 months, his duties are not clearly stated. Even an appeal by a State Agency from a decision of the Director of the Office of Medical and Hospital Care Services is to be made directly to the Courts, thereby circumventing the Administrator—page 23, lines 18 and 19.

It is recommended that the responsibilities and authority of the Administrator be clearly defined. In the execution of these responsibilities he should have the advice and help of a National Advisory Health Council. This Council should be composed of the Directors of the various subdivisions of the Agency ex officio, outstanding representatives of medicine, dentistry, nursing, maternal and child care, medical social work, public health and representatives of the public.

Section 102 (c) (5): After the word "training" add the word "restoration."

Section 104 (c): The Director of the Office of Medical and Hospital Care Services should be a licensed doctor of medicine but, of necessity, he should be outstanding not only in the field of medicine but also should have demonstrated exceptional administrative capacity. The words "at least 5 years of active medical practice" add nothing significant to the required qualifications and might be used to prevent consideration of a person of recognized medical leadership but who had never engaged in active private practice for fees, like the late Dr. William H. Welch, whose medical leadership and administrative capacity was nevertheless recognized by his elevation to the presidency of the American Medical Association and the direction of other important medical enterprises, such as the School of Public Health at Johns Hopkins University.

In section 104 (d), page 10, line 11, replace the words "Surgeon General" with the word "Administrator."

Title II, section 203 (c): In our opinion, consideration of an appropriation for the prevention and control of any one disease, such as cancer, should be omitted from this bill. It would be more appropriate to make such an appropriation in an omnibus measure dealing with grants-in-aid to the States for the prevention and control of various diseases which require Federal support. Furthermore, the provision of facilities for the early diagnosis of cancer cannot be distinguished from the provision of adequate facilities for medical and hospital care.

Senator SMITH. May I interrupt you there, Doctor, for just a minute? I gather that you feel that the reference to cancer research has been taken out of this bill entirely?

Dr. BAEHR. Yes, sir, the bill (title II) refers to prevention and control of cancer, which is quite different than cancer research.

Senator SMITH. I might say, Doctor, we have just passed in the Senate the Scientific Research Foundation bill, as you may have seen in the papers, and we provided in that bill an amendment setting up a special commission to deal with cancer and heart ailments, and I think because of that, if the bill is passed, gets through the House and is passed by the Congress, I should think it would justify elimination of this paragraph entirely from this bill, if you approve of it?

Dr. BAEHR. Yes, sir.

Senator SMITH. You would rather see research in a field like cancer provided for in the scientific research bill?

Dr. BAEHR. Yes, sir. Section 712 (a) (4) (b), page 18, line 10. Change the word "physical" to "health." It might better be replaced by the words "health examination."

Section 712 (a) (4) (b), page 18, line 15: It seems to us to be most important to change the last word "or" to "and", and to eliminate the option expressed in lines 13 to 15, which would authorize the grantee States to limit their programs to fractional services. You see, we favor comprehensive service as the most important feature of medical care, because it includes preventive services.

Section 712 (a) (4) (b), page 18, lines 21 and 22: We are in doubt as to whether the words "other fund" include a State compulsory medical insurance fund. We believe that such a State fund should not be excluded if the State prefers it. In fact, we have recommended that it might even be desirable to have comparative experience between a State compulsory medical insurance fund and other methods of providing prepaid medical care through voluntary medical insurance funds supported by the State and Federal Governments.

Page 20, line 23: We suggest there changing the word "health" to "medical care." Also the same change on page 27, line 5.

Then on page 24, line 24, change the words "Surgeon General" to "Director."

Title VIII, section 802 (a) (2) and section 812 (a) (2): Include outstanding representatives in medicine and medical research on the State Advisory Dental Councils.

Sections 902 and 903. We regard dental research as dependent in large part upon general research in the medical sciences and consider it contrary to the best interests in dental progress to separate dental research so sharply from general research under the National Institute of Health or a National Science Foundation. Section 904 and 905 and part B, section 911: For the same reason we consider it as inadvisable for the Congress to establish an independent National Institute of Dental Research as to establish an independent National Institute for cardio-vascular diseases, diabetes, or any of the numerous branches of medicine. We are quite apt to go too far in establishing independent institutes in each of the various disciplines of medicine.

All funds for grants-in-aid to support medical research should continue to be administered by the National Institute of Health of the Public Health Service as at present, until such time as a National Science Foundation is established.

We see no justification for weakening the present activities of the United States Public Health Service by placing the assembling of health statistics and the administration of the Hospital Survey and Construction Act of 1946 in separate divisions of the agency. We also recommend that the health and medical research program of the Public Health Service be strongly supported. There are opportunities for the wider extension of health services by the Public Health Service in many counties and localities in this country that do not now have any public health services or only most inadequate services.

Finally, the bill should be so revised, we think, that the National Health Agency will fit into a new department of Federal Government, if created by the passage of the Aiken bill or the Taft-Fulbright bill.

Senator SMITH. Doctor, we appreciate your fine contribution to this subject, and we would like now to have a little opportunity to question you further. I will ask Senator Murray if he has any questions to start with that he would like to present to Dr. Baehr.

Let me ask Dr. Baehr first—we have with us today Dr. Craig, Dr. Howard Craig, and Dr. Iago Galdston. I did not know whether you intended for them to appear to supplement your testimony, or whether you would rather present the case from the academy standpoint and dispose of your testimony before we call on them.

Dr. BAEHR. We agreed that it might be better if I tried to answer whatever questions may be directed at me, and they would be prepared to provide supporting data or answer any questions to which I might not feel competent to reply.

Senator SMITH. Senator Murray, do you have any questions?

Senator MURRAY. Doctor, I would like to have you tell the committee what your committee on medicine and the changing order found to be the most serious shortcomings of the voluntary plan?

Dr. BAEHR. The most serious shortcomings of the voluntary plans were twofold. Voluntary plans have some of the same defects as compulsory plans, in that if the medical services to be rendered by physicians are paid for in accordance with the present fee-for-service system of medical practice, abuses from the standpoint of the consumer and the physician who renders the service become exceedingly common, and a break-down in medical standards is quite apt to occur. We acknowledge that likelihood.

The other deficiency in voluntary plans is that they require some financial support from some source, governmental or voluntary, during the early stages of operations, in order to get under way. Do you want me now to mention the advantages?

Senator MURRAY. What would be the essential ingredients of a good plan? What would be the requirements?

Dr. BAEHR. A good plan must include sufficient flexibility to allow and even encourage experimentation with new and better methods of rendering medical service, which can be made to function economically and efficiently under the prepayment program.

Senator MURRAY. It should provide for a high quality of care, and be comprehensive?

Dr. BAEHR. It must provide comprehensive medical services of high quality, and quality will largely depend upon the method of organizing the medical services, checking them and improving them, and eliminating the deficiencies as they occur during the gradual adoption of the program by large segments of the population.

Senator MURRAY. Of course, I have in mind not a national comprehensive program, but local programs. Does that apply to local programs of voluntary methods?

Dr. BAEHR. Yes; it applies to local programs.

Senator MURRAY. You would say that the care, to be proper, should be comprehensive and should be preventive as well as curative?

Dr. BAEHR. Yes.

Senator MURRAY. Can the group plan help to maintain the quality of care?

Dr. BAEHR. It can. Medicine practice groups are in a more advantageous position to accept capitation payments, their work can also be more readily supervised and checked, so that the quality of medical care which they render can be brought up to a high standard.

Senator MURRAY. And should be more economical?

Dr. BAEHR. Their work can also be done more economically.

Senator MURRAY. Can you give us the name of some voluntary plans that you consider comprehensive, that used the group practice system?

Dr. BAEHR. There is one in New York now under way, the Health Insurance Plan of Greater New York, which is based entirely upon group medicine practice. About 22 groups have been established and are beginning to operate. They have not been in existence long enough to indicate just what difficulties may be encountered, and how much support is necessary to carry them through the first year. It is already apparent that they need financial support, at least in the early months of operation.

Senator SMITH. Is that the program that Dr. Dean Clark is executive of?

Dr. BAEHR. Yes; he is the medical director.

Senator SMITH. He made a statement for the record of what progress they had made, what their experience has been, both pro and con. I hope we will have that before the hearing.

Dr. BAEHR. The Health Insurance Plan of Greater New York is one of the experiments that I think has an opportunity to demonstrate to this country how better medical services can be rendered under a prepayment plan by better organization at the local level.

Senator MURRAY. Can you tell us any other group plans besides the plans in New York?

Dr. BAEHR. Individual medical groups have operated successfully under a prepayment plan, like the Ross-Loos Clinic, of Los Angeles, as you know, and also similar groups in other parts of the country, but there has been no large community, other than in New York, that has attempted to establish a medical insurance plan in which medicine services are provided through a large number of medical practice groups to all subscribers.

Senator MURRAY. And they undertake to give comprehensive care?

Dr. BAEHR. They undertake to give comprehensive care; yes.

Senator MURRAY. Then your committee believes that it is feasible to have comprehensive plans with good-quality care?

Dr. BAEHR. It is feasible to have comprehensive, good-quality care, but it will take a certain amount of experimentation as well as guidance and experience in order to learn how to set them up. The reason that voluntary medical insurance plans to provide comprehensive medical service through group practice units have not been organized and operated in other large communities is because of the absence up to this time of State or Federal interest and support. The program in New

York, for example, has had to secure its financial support from private philanthropic foundations, and there is a limit to that kind of support for a very large program.

Senator MURRAY. Well, the experience in New York indicates, then, that it would be possible and that it would be desirable?

Dr. BAEHR. Yes.

Senator MURRAY. On page 3 of your testimony, Doctor, you say that services should be comprehensive. Can you tell me how many medical prepayment plans are comprehensive now?

Dr. BAEHR. The Health Insurance Plan of Greater New York, the Ross-Loos Clinic, and the Permanente plans are comprehensive. Others like the California Physicians Service and the Michigan plan started as comprehensive, but they were soon obliged to abandon comprehensive services, because they were based entirely upon individual fees for every individual service. It is not possible to provide comprehensive medical service except through medical practice groups paid on a capitation basis.

Senator MURRAY. Do you feel that the minimum Federal standards should be established in any of these programs?

Dr. BAEHR. I do.

Senator MURRAY. Could you give us a short, brief statement of what you consider would be minimum standards?

Dr. BAEHR. It is difficult to state them in a few sentences. This is a matter for a national council at the top level of the agency or for the medical care agency division of the national agency to set up. There are many details which would have to go into such a set of standards. It would be necessary for the Federal agency, which is responsible for the allocation of Federal funds, to promulgate these standards.

Senator MURRAY. I understand that yesterday the doctors representing the American Medical Association talked about limited-service plans controlled by medical societies, but they did not make any reference to necessary comprehensive plans that you have told us about. Doesn't the American Medical Society recognize what you have stated to be the fact?

Dr. BAEHR. I think it does. I think the attitude of the American Medical Association is that it is possible right now to establish limited-service plans. The association recognizes that comprehensive medical service on a fee-for-service basis is more difficult to establish, perhaps impossible, without modifying the present methods of medical practice for which the profession is as yet unprepared. The association, therefore, advocates only limited-service plans as a first step in a broader program of the future. The academy's attitude goes well beyond that limitation. We feel that limited-service plans are all right as far as they go, but they are not a true health measure for which the Federal Government ought to concern itself.

Senator MURRAY. I understand, Doctor, that you are endorsing this bill in principle, but that you have these many recommendations which you feel are essential before you give it your full endorsement.

Dr. BAEHR. Yes; we think these recommendations are most important. The bill would not operate effectively unless the bill is amended in accordance with these recommendations.

Senator MURRAY. Thank you, Doctor.

Senator SMITH. Doctor, I would like to ask you one question which has been prompted by the first question that Senator Murray asked you, where you speak of limitations in the voluntary insurance plan. Of course, we have before us this important issue as to whether we should put into operation in this country an over-all compulsory insurance plan where everybody contributes through a pay-roll tax to a fund which is used for carrying on this health business. That is one side. On the other side is a voluntary insurance plan, as the spirit of this bill is, which decentralizes the responsibility to the States and has the States developed by trial and error, by experiment with various plans, and, as you say, according to certain standards, of course, minimum standards, but to go on their own to see which is the best way to take care of this problem. I would like for you to bring out this fact: Where do you as a group—as I understand you do—find objection to the compulsory insurance plan?

Dr. BAEHR. The compulsory insurance plan as we see it proposes to tax 140,000,000 people with the promise that in return for that special tax they will all receive free comprehensive medical care, something which we feel sure from our knowledge of the situation of medical care and medical service in this country, cannot be delivered. We therefore prefer Federal assistance to the States, following a careful survey and preparation of plans for medical care that have a reasonable possibility of success. Supported by Federal and by State funds, various local areas will adopt a variety of worthy programs and out of these, in the course of a very few years, will come a variety of experiences which will indicate, as in the evolution of workmen's compensation insurance, how to do a competent job, how to deliver medical services of high order in return for the contribution which the workers and their employers will make as prepayment. We believe that Nation-wide adoption of the compulsory health insurance, a universal tax on all people with a promise of free medical care, would result in confusion and great disappointment, because the required medical services do not exist in many parts of the country nor will they be created merely by assembling a large Federal tax fund for the payment of medical bills.

Senator SMITH. You feel, then, if I understand you correctly, that if we had an over-all tax to take care of the over-all health insurance of everybody, the Government simply could not deliver what it was represented as prepared to deliver in return for that tax?

Dr. BAEHR. That is the point; yes, sir.

Senator SMITH. I will ask Senator Donnell if he has some questions. Then I will ask you a few more, if I may.

(Senator Pepper took a seat at the committee table.)

Dr. Baehr, this is Senator Pepper, of Florida. Senator, this is Dr. George Baehr, president of the New York Academy of Medicine, testifying as to the plans they have worked out on this study of medicine in the changing order.

Senator PEPPER. I am sorry I missed the first part of your testimony, Doctor.

Senator DONNELL. Doctor, I would like to address some questions to you relating particularly to this volume entitled "Medicine in the Changing Order." I note from the cover on the book that it is entitled

"Report of the New York Academy of Medicine Committee on Medicine and the Changing Order." That is correct, is it not?

Dr. BAEHR. It is.

Senator DONNELL. This committee was authorized, as I observe from the introduction, in December 1942, and the first meeting of the whole committee was held on February 25, 1943. Before mentioning some of the findings of the committee in this report I would like to pause to have brought into the record here certain factual material as to the method that was used by this committee and the thoroughness with which the committee approached the problem. As I understand it from the introduction, in the spring of 1943 the objectives of the committee were stated in certain language set forth on page ix of the introduction to this book. Was it then agreed that the information and opinions should be solicited from a wide variety of authorities, Doctor?

Dr. BAEHR. It was.

Senator DONNELL. And it is correct to state—and I am quoting in substance from this introduction—that those consulted represented every shade of economic, social, and political conviction that might have a bearing on medical care? Is that right?

Dr. BAEHR. Quite right.

Senator DONNELL. And it is true likewise that in all some 50 men and women addressed the committee in a period of time covering 16 months?

Dr. BAEHR. That is quite right.

Senator DONNELL. At the conclusion of that phase of your study, that is, the 16 months, did this committee then cause to be appointed some 11 subcommittees to correlate what is termed in the introduction the "mass of information" which had been presented, and to make special investigations and to make recommendations to the whole committee?

Dr. BAEHR. That is correct.

Senator DONNELL. And the committee, I believe, also selected titles and authors of a dozen monographs to be published by the Commonwealth Fund?

Dr. BAEHR. That is correct.

Senator DONNELL. You referred a little earlier this morning to the fact that these volumes were produced, as I understand it, under great freedom of thought, so that any person, regardless of whether his thought was orthodox or nonorthodox, according to various principles then prevailing, would be permitted to express himself freely and fully?

Dr. BAEHR. That is quite right. And the character of the authors will indicate that they would not have agreed to publish these volumes if they had been so influenced.

Senator DONNELL. And, as indicated earlier in your testimony this morning, quoting from a portion of this introduction, individual authors were given free rein in the presentation of monographs?

Dr. BAER. They were.

Senator DONNELL. I think there were some 11 that they actually published?

Dr. BAEHR. That is correct.

Senator DONNELL. Now, Doctor, I would like to ask you whether or not certain foundation funds became interested in the development of the work of this committee, notably, the Commonwealth Fund, Millbank Memorial Fund, Josiah Macy, Jr., Foundation; is that correct?

Dr. BAEHR. Yes; they supported the work through grants.

Senator DONNELL. And I note, Doctor, that on the flyleaf of this report, which is dated 1947, it mentions the Commonwealth Fund down at the bottom of the page. I assume the Commonwealth Fund finances the publication of this report?

Dr. BAEHR. Yes, the fund has a publications division.

Senator DONNELL. What is the Commonwealth Fund?

Dr. BAEHR. It is a philanthropic foundation, a nonprofit organization.

Senator DONNELL. It is located in New York City, is it?

Dr. BAEHR. The chief offices are in New York City.

Senator DONNELL. Is it correct to say, Doctor, that the committee on medicine and the changing order, namely, the committee which issued this report entitled "Medicine in the Changing Order," was composed of 33 physicians and 17 representatives of allied professions and lay persons?

Dr. BAEHR. Yes; that is correct.

Senator DONNELL. Now, the physicians were chosen, I take it, as indicated in the introduction, because of their interest in medical education and public health. There was also strong representation from the fields of nursing and dentistry?

Dr. BAEHR. That is right.

Senator DONNELL. Is it correct also to say that the lay members were selected from the fields of the ministry, the law, social welfare, hospitals, insurance, labor, and industry? Is that correct?

Dr. BAEHR. That is correct.

Senator DONNELL. I think it is quite important, Doctor, in connection with the ultimate findings which I am going to direct your attention to in a moment, to have your comments briefly on some of the personnel of this committee which issued this report. Dr. Malcolm Goodridge is the chairman of the committee, is he not?

Dr. BAEHR. He has been chairman throughout.

Senator DONNELL. And who is Dr. Goodridge?

Dr. BAEHR. Dr. Goodridge is a distinguished physician who has had a long and successful practice in medicine in New York City, and who is professor of clinical medicine at Cornell University Medical School and New York Hospital.

Senator DONNELL. Has he had actual, practical experience in the practice of medicine?

Dr. BAEHR. Yes.

Senator DONNELL. Is he a surgeon?

Dr. BAEHR. He is a physician, an internist.

Senator DONNELL. And he has had wide experience, has he, in actual, practical, professional practice?

Dr. BAEHR. That is correct.

Senator DONNELL. Now, I note the first man listed on this list of members is Dr. Donald B. Aldrich. By "Doctor" I mean a distinguished minister from Boston.

Dr. BAEHR. No; Aldrich is the second vice president of the Metropolitan Life Insurance Co.

Senator DONNELL. Donald B. Aldrich, D. D.?

Dr. BAEHR. No; he is a clergyman. I was thinking of Armstrong.

Senator DONNELL. He is a clergyman?

Dr. BAEHR. Yes, sir.

Senator DONNELL. Is he located in New York City?

Dr. BAEHR. Yes; I think so.

Dr. CRAIG. He is in Princeton.

Dr. BAEHR. He is in Princeton, N. J.

Senator SMITH. Dr. Aldrich was rector of the Episcopal Church on Fifth Avenue in New York, and he is presently chaplain at Princeton University.

Senator DONNELL. The Senator was formerly a member of the faculty at Princeton University.

I am going to call your attention—I am going to leave out the doctors for a moment and call your attention to the next name listed alphabetically among the laymen, a lay woman, Mrs. August Belmont. Is Mrs. Belmont quite active in matters of philanthropy and public endeavor of one kind and another?

Dr. BAEHR. Especially in nursing. She has been very active in Red Cross work and has wide acquaintance with medical and social work as well.

Senator DONNELL. Dr. Malcolm W. Carr; doctor of dental science, is he not?

Dr. BAEHR. Yes, sir.

Senator DONNELL. He is located in New York City?

Dr. BAEHR. He is located in New York.

Senator DONNELL. And Dr. Henry Sloane Coffin is a member of the clergy, is he not?

Dr. BAEHR. Yes.

Senator DONNELL. And Mr. John W. Davis——

Senator SMITH. Let me interrupt just a minute. What did you say about Dr. Henry Sloane Coffin?

Dr. BAEHR. He is officially retired. He was president of Union Theological Seminary.

Senator SMITH. Yes; he served in that capacity for many years after being pastor of the Madison Avenue Presbyterian Church.

Dr. BAEHR. That is right.

Senator DONNELL. John W. Davis is one of the most eminent lawyers in the United States, is he not?

Dr. BAEHR. Yes.

Senator DONNELL. Was a candidate on the Democratic ticket for President of the United States some years ago?

Dr. BAEHR. Yes, sir.

Senator DONNELL. And was also president of the American Bar Association?

Dr. BAEHR. Quite right.

Senator PEPPER. Did Mr. Davis get your support, Senator? [Laughter.]

Senator DONNELL. I was too young. [Laughter.]

Mr. Walter S. Gifford of the American Telephone & Telegraph Co., president of that company, is he not?

Dr. BAEHR. Yes, sir.

Senator DONNELL. He is also on the committee. And Dr. Joseph C. Hinsey, Ph.D.?

Dr. BAEHR. He is dean of Cornell Medical School.

Senator DONNELL. And how does he happen to have Ph.D. here listed?

Dr. BAEHR. Because he has been interested in medical administration. That is his field of work. And he is a Ph.D., not an M.D.

Senator DONNELL. And Mr. Franklin B. Kirkbride. He is a layman, is he? And who is Mr. Kirkbride?

Dr. BAEHR. Mr. Kirkbride has been interested in mental hygiene. He is head of the board of directors of one of the epileptic colonies in New York State and a man of very broad philanthropic interest in social work.

Senator DONNELL. Do you know if he has paid any attention to the matter of dementia praecox, studies of that kind?

Dr. BAEHR. No; I don't know.

Senator DONNELL. I don't know whether he has or not. I am inquiring as a matter of information. It happens that one of the great fraternal orders in this country has devoted a large sum of money to the study of that subject, and I was wondering, without any knowledge on my part pro or con, whether Mr. Kirkbride is connected with that work.

Dr. BAEHR. I could not tell you that.

Senator DONNELL. Mr. Louis Pink. Who is he?

Dr. BAEHR. He is president of the Blue Cross Plan of New York, the associate hospital service of New York.

Senator DONNELL. Mary M. Roberts, registered nurse?

Dr. BAEHR. She is one of the outstanding leaders in nursing education.

Senator DONNELL. Dr. Richard H. Shryock is professor of history of the University of Pennsylvania, is he not?

Dr. BAEHR. He is; yes.

Senator DONNELL. And your attention is called in this report to his services as being particularly of the type that merits special mention, or words to that effect. That is correct, is it not?

Dr. BAEHR. He has given a great deal of attention to it.

Senator DONNELL. And Miss Grace Warman, registered nurse, is she likewise active in the nursing field?

Dr. BAEHR. She is director of nurses at Mount Sinai Hospital, New York.

Senator DONNELL. And Dr. Leo Wolman, Ph.D., who is Dr. Wolman?

Dr. BAEHR. He is an expert in public health, a sanitary engineer.

Dr. CRAIG. No; that is his brother. Leo Wolman is an economist.

Dr. BAEHR. Leo Wolman is an economist. I had him confused with his brother.

Senator DONNELL. Dr. Iago Galdston is here this morning. He is secretary of the committee?

Dr. BAEHR. Yes.

Senator DONNELL. And, as has been indicated in the report, Dr. Galdston not only was a member of the committee and is the secretary, doing much of the spade work which determined the successful development of the study, but at the same time discharged his full responsibility as executive secretary of the committee on medical information, one of the important standing committees of New York Academy of Medicine?

Dr. Baehr. Yes, sir.

Senator Donnell. Would you tell us about Dr. Miller, what connection Dr. Miller had with this matter?

Dr. Baehr. Dr. Miller was one of the great leaders in public health and medicine in this country. He has been president of the National Tuberculosis Association and is a practicing physician who is perhaps the best known expert in the field of tuberculosis in this country.

Senator Donnell. That is Dr. James Alexander Miller?

Dr. Baehr. Yes. He has also been chairman of the committee on public health relations of the New York Academy of Medicine for 12 or 14 years.

Senator Smith. I notice, that this paper which you read this morning, the statement was offered by you in behalf of yourself, Dr. James Alexander Miller, Dr. Galdston, and Dr. Craig. That is the same Dr. Galdston who is here with you?

Dr. Baehr. Yes. Dr. Miller intended to be present and give testimony, but he was not well enough to come to Washington.

Senator Donnell. And this is Dr. Howard Craig who is with you?

Dr. Baehr. Yes, he is here with us.

Senator Donnell. He is sitting right here by Dr. Galdston. And has he been quite active on this committee?

Dr. Baehr. He is director of the academy.

Senator Donnell. I will try not to be tedious, but I do think it is very important, because of the nature of the findings here, that we mention briefly the doctors who are on this committee. Who is Dr. Harry Aranow?

Dr. Baehr. He is one of the most outstanding and most experienced obstetricians in New York City. He practices in the Bronx, N. Y.

Senator Donnell. Dr. Baehr, you have stated something briefly of your own qualifications. Is there anything in your professional specialty that you desire to add to what you have already stated?

Dr. Baehr. I think I have covered it in my statement, Senator.

Senator Donnell. Dr. David P. Barr, M. D.?

Dr. Baehr. Dr. Barr has been professor of medicine at Washington University, St. Louis, and is now professor of medicine at Cornell Medical School.

Senator Donnell. How does Washington University rank, and how does St. Louis rank in the country as a medical and hospital center?

Dr. Baehr. Washington University Medical School is one of the best, and St. Louis is one of the greatest medical centers in the country.

Senator Donnell. The State of Missouri ranks right at the top in many respects, does it not?

Dr. Baehr. New York had to go to St. Louis to get a professor of medicine.

Senator Smith. That will please your constituents that the distinguished State of Missouri is now highlighted in this bill. I compliment Senator Donnell.

Senator Donnell. Thank you, sir.

Senator Smith. Missouri is a great State.

Senator Donnell. We are agreed on that.

Senator Smith. New Jersey is going to have its say a little later.

Senator Donnell. Dr. Robin C. Buerki?

Dr. **Baehr.** Dr. Buerki is a great hospital administrator. He was professor of hospital administration at Wisconsin University, and is now head of the graduate school of the University of Pennsylvania and professor of hospital administration there.

Senator **Donnell.** Dr. Howard Craig?

Dr. **Baehr.** Dr. Craig is a pediatrician. He is here today. He has had long experience in pediatric practice and is now director of the New York Academy of Medicine.

Senator **Donnell.** Dr. Curran?

Dr. **Baehr.** Dr. Jean Curran is dean of the Long Island College Medical School, and was formerly at the Peiping Union Medical College.

Senator **Donnell.** Dr. Condict W. Cutler, Jr.?

Dr. **Baehr.** Dr. Cutler is an outstanding surgeon, chief of surgery at Roosevelt Hospital, New York.

Senator **Donnell.** I observe that Julius Emspak was a member of the committee, but resigned June 27, 1946. He was, however, connected with the committee, I take it, from its inception, or approximately that, until his resignation. Is that correct?

Dr. **Baehr.** That is right.

Senator **Donnell.** Would you state, please, who Mr. Emspak is?

Dr. **Baehr.** I think Dr. Galdston might give us that.

Dr. **Galdston.** I think I can supply that. He is general secretary-treasurer of the United Electrical and Radio Machine Workers of America, CIO.

Dr. **Baehr.** That is right.

Senator **Donnell.** Does Mr. Emspak devote time and thought to the work of this committee like anybody else, even though he resigned in 1946, several years after the committee was established?

Dr. **Galdston.** He was never present at the meetings, although he was invited to be present. He once sent one of his representatives who read a paper that was included in our report.

Senator **Donnell.** Miss Katherine Faville. Who is Miss Faville?

Dr. **Baehr.** Miss Faville was head of the visiting service in New York at one time and is now head of the nursing school at one of the western universities.

Senator **Donnell.** Mr. Homer Folks?

Dr. **Baehr.** Mr. Folks is one of the outstanding leaders in social work in this country, and at that time was head of the New York State Charity Aid Association.

Senator **Donnell.** Dr. Edward S. Godfrey, Jr.?

Dr. **Baehr.** Dr. Godfrey was commissioner of health of the State of New York.

Senator **Donnell.** Dr. Alan Gregg?

Dr. **Baehr.** Dr. Alan Gregg is Medical Director of the Rockefeller Foundation.

Senator **Donnell.** Dr. William W. Herrick. He is deceased. Did he participate before his death?

Dr. **Baehr.** Yes, he was a practicing physician, professor of clinical medicine at Columbia University.

Senator **Donnell.** And Dr. Shepard Krech?

Dr. **Baehr.** Shepard Krech is a surgeon, formerly one of the chief surgeons at Bellevue Hospital.

Senator DONNELL. Dr. Henry E. Meleney?

Dr. BAEHR. He is professor of preventive medicine, New York University Medical College.

Senator DONNELL. We have already referred to Dr. Miller. Is there anything you wish to add, any comments on Dr. Alexander Miller?

Dr. BAEHR. No, I think he is well enough known.

Senator DONNELL. Dr. Harold R. Mixsell?

Dr. BAEHR. Dr. Mixsell is a pediatrician with one of the largest pediatric practices in New York.

Senator DONNELL. Dr. Claude W. Munger?

Dr. BAEHR. Dr. Munger is a hospital expert and director of St. Luke's Hospital in New York.

Senator DONNELL. Dr. Bernard S. Oppenheimer?

Dr. BAEHR. Dr. B. S. Oppenheimer is an outstanding physician who has made important contributions in the field of cardio vascular diseases.

Senator DONNELL. Dr. Walter W. Palmer?

Dr. BAEHR. Dr. Palmer is professor of medicine at Columbia University.

Senator DONNELL. Dr. Eugene H. Pool?

Dr. BAEHR. Dr. Eugene Pool was professor of surgery at Cornell Medical School Hospital, New York.

Senator DONNELL. Dr. Robert E. Pound?

Dr. BAEHR. Dr. Pound is a distinguished roentgenologist.

Senator DONNELL. Dr. Tracy J. Putnam?

Dr. BAEHR. Tracy Putnam was professor of neurology at Columbia University. He formerly practiced in Boston.

Senator DONNELL. Dr. Willard C. Rappleye?

Dr. BAEHR. Dr. Rappleye is dean of the College of Physicians and Surgeons, and formerly was professor of hospital administration at Yale.

Senator DONNELL. Dr. Paul Reznikoff.

Dr. BAEHR. Paul Reznikoff is a practicing physician who is on the staff of the New York Hospital.

Senator DONNELL. Dr. Thomas M. Rivers?

Dr. BAEHR. Thomas Rivers is director of the Hospital of the Rockefeller Institute.

Senator DONNELL. Dr. Donal Sheehan?

Dr. BAEHR. Dr. Donal Sheehan was acting dean at that time of the New York University Medical School.

Senator DONNELL. Dr. Wilson G. Smillie?

Dr. BAEHR. Dr. Smillie is professor of preventive medicine, head of the department of public health and preventive medicine at Cornell Medical School.

Senator DONNELL. Dr. Ernest L. Stebbins?

Dr. BAEHR. Dr. Stebbins was commissioner of health for the city of New York and is now head of the school of public health at Johns Hopkins University.

Senator DONNELL. Dr. William S. Tillett.

Dr. BAEHR. Dr. Tillett is professor of medicine at New York University Medical School and head of medical services for the third and fourth divisions of Bellevue Hospital.

Senator DONNELL. Dr. Edward Tolstoi?

Dr. BAEHR. Dr. Tolstoi is a specialist in diabetes, a practicing physician.

Senator DONNELL. J. Raymond Walsh, Ph.D. He resigned October 31, 1946. Did he participate in the work of the committee?

Dr. BAEHR. I think Dr. Galdson might answer that.

Dr. GALDSTON. He is now a radio publicist, but he was at the time connected with the union.

Senator DONNELL. He participated in the work of the committee?

Dr. GALDSTON. Only very slightly. He was not present at the meetings of the committee. He was invited to be present and then address the committee.

Senator DONNELL. Dr. Walsh was director of the department of education and research of CIO, possibly still is?

Dr. GALDSTON. No; he is not now.

Senator DONNELL. Dr. Herbert Wilcox?

Dr. BAEHR. Director of the academy, formerly professor of pediatrics at Columbia, and a practicing pediatrician.

Senator DONNELL. Dr. I. Ogden Woodruff?

Dr. BAEHR. Dr. I. Ogden Woodruff is a practicing physician, internist, who is now head of the health council of greater New York, and a worker in the field of public health as well as medicine.

Senator DONNELL. I take it, Doctor, you agree with the comment of Dr. Goodridge:

> I am convinced that the reader will be as impressed as I am that an unusually competent group of men and women, who had already evinced great interest in the general subject, were selected to try the question which one day must be answered if we are to have adequate medical care made available to more people in this country.

You agree, Doctor, that in justice that observation would apply both to the members of the committee and to the persons who participated and cooperated in the work?

Dr. BAEHR. I am sure of that.

Senator DONNELL. Just one or two more questions, Doctor. Then I will pass on to what the committee found. This committee was very active, was it not? In fact, it held 120 meetings in a little over three years? Is that correct?

Dr. BAEHR. That is correct.

Senator DONNELL. And attendance is characterized in the introduction as excellent at all meetings. Is that correct?

Dr. BAEHR. Yes, sir.

Senator DONNELL. Now he states in the introduction:

> While we do not give approval to compulsory health insurance at the present time—

the words—

> at the present time—

are italicized—

> we also disapprove at the present time—

again italicized—

> any other form of prepaid, full coverage insurance to be applied as suitable for all sections of the country.

Then I will close this comment on personnel and the type of work of the committee before taking up what is found, with this paragraph, and ask you if you agree with this:

> Whatever views may be entertained on the subject of medical care and its distribution, I think that whoever reads this report will find it a judicial, unbiased, and constructive study, and it is on this basis that we are offering it to the pubilc for their consideration and information.

That is Dr. Goodridge speaking. Do you agree with that?

Dr. BAEHR. I do.

Senator DONNELL. Now, Doctor, on page 208 of this report there is a subheading entitled "Compulsory medical insurance"—this, by the way, is found in the chapter on medical insurance, voluntary and compulsory—I observe this language on page 208 and ask you if you concur in it:

> The appreciation of the difficulties and problems involved in the extension of voluntary medical insurance has persuaded some to advocate in its stead a system of national compulsory medical insurance to be enacted by Congress and to be administered under central national supervision. Other advocates of compulsory medical insurance derive their persuasions not from a knowledge of the potentialities and limitations of voluntary insurance, but rather from certain social philosophies which look to central government for the organization and administartion of most phases of communal and individual existence.

Without expressing yourself at the moment as to the advisability of national compulsory medical insurance, do you concur with the statements set forth in that paragraph, the contents of that paragraph?

Dr. BAEHR. I do.

Senator DONNELL. Then, Doctor, the committee proceeds with the statement that it naturally devoted much time and energy to the study of this agitated and controversial matter, and approached it with an eagerness to learn all that it substantially involves. I call your attention to the next sentence, which I think is of some importance:

> One thing became apparent at once, namely, that our knowledge of voluntary medical insurance was derived from experience, whereas of compulsory insurance we know but little, and that mainly from European experience. It is possible, therefore, to give weighty consideration to both the advantages and the difficulties of voluntary insurance, because they are real, being founded on experience, while all that pertains to compulsory insurance is and must be considered to be conjectural.

Do you agree with that statement?

Dr. BAEHR. Yes, sir.

Senator DONNELL. Now, Doctor, so that our record may be perfectly clear, this document that I am reading from is the report of this committee, the personnel of which I have gone into rather extensively, and I hope not unduly tediously but rather in detail, and everything here is a part of the report of that committee. That is correct, is it not?

Dr. BAEHR. It is.

Senator DONNELL. I notice, Doctor, on page 209 of that report this language, and I will ask you if you concur with this from your experience and observation:

> Though the committee drew upon testimony available on the European experience with compulsory medical insurance, it was not restricted in its studies to those limits. For the advocated schemes of national compulsory medical

insurance involve many legislative, organizational, relational, administrative, and economic phases upon which social legislation now in operation affords as much and illuminating experience. Drawing upon these and other related data, the committee was led to the conclusion that national compulsory medical insurance would not and could not realize the promise made for it, and would inevitably create new and formidable evils of its own. Any scheme of national compulsory medical insurance at this time—

underscored—

would lead to most unfortunate results affecting the health of the public and the science as well as the practice of medicine.

Do you agree with those statements?

Dr. BAEHR. We are convinced of the truth of that statement.

Senator DONNELL. Now, Doctor, I notice the next sentence:

> The advocated schemes for the prepayment of medical costs by the enactment of compelling legislation and the collection of tax monies are deceptive in their simplicity. For, as the committee's studies have shown, the problem of providing for extension of medical care is far from simple; indeed, it is extremely complex, involving as it does not only readjustments in the care of the sick, but also the structure and content of medical education and the broad fields of social, industrial, and preventive medicine. Experience shows that although under compulsory medical insurance on a Nation-wide scale a larger number of people receive medical service, the quality of medical service rendered by the individual physician tends to decline.

Do you agree with the statements made in the paragraph I have read?

Dr. BAEHR. I think that is susceptible of proof by theory and by experience.

Senator DONNELL. Without reading it, I will call attention to the note at the bottom of that page, note 7, which is a quotation from Dr. Hermann Levy, National Health Insurance: a Critical Study. I think I will read that and ask you if you concur with it. "It should be noted"—this is the note of Mr. Levy—by the way, who is Mr. Levy, if you know, Hermann Levy?

Dr. BAEHR. He is an economist, I think.

Dr. Galtston is quite well acquainted with his book.

Dr. GALDSTON. I think he is English, an outstanding authority on the insurance schemes of England, and he has written extensively and critically, but constructively, of the practice there.

Senator DONNELL. Now they have compulsory medical insurance over there in England, have they not?

Dr. GALDSTON. A limited form.

Senator DONNELL. About 40 percent, is it not?

Dr. GALDSTON. It involves, up to the present time, the worker, and does not include anything more than the home and office care, but the future program is much more comprehensive than that.

Senator DONNELL. Now I quote from Mr. Levy:

> It should be noted that it is not only the physical burden and the hard economic struggle that account for such dissatisfaction among panel doctors, but also the moral and psychological discontent with work which was once begun with the object of satisfying some scientific and cultural personal ambition, and which ends in the monotony and drudgery of hopeless clerical routine work. * * *
>
> Pressure of work, the temptation of better-paid jobs, the constant necessity of balancing private against insurance practice, the difficulty of making a living which is socially justified from the viewpoint of a learned profession and permits the repayment of expenditure and expenses on his career, dissatisfaction

with work which, because of the clerical duties involved, after some time degenerate into a lifeless routine—all these circumstances go far to explain why the complaints about unsatisfactory, careless and even negligent medical service by the panel doctor are only too well founded.

That is quoted from Mr. Levy's work on National Health Insurance, a Critical Study, issued by the National Institute of Economic and Social Research, economic and social studies IV, London, Cambridge University Press, 1944, pages 135–136. Do you know of the standing of that institute and whether or not it does have a high reputation professionally?

Dr. BAEHR. Yes; I believe it does.

Senator DONNELL. That is cited in a note by this committee whose report is quoted in this volume from which I have been reading, is it not?

Dr. BAEHR. Yes, sir.

Senator DONNELL. Now, Doctor, I call to your attention—first, I will ask leave, Mr. Chairman, if I may, to file with the committee a little later on this entire volume, but for the purpose of the record at the moment I would like to read a little further from this.

Senator SMITH. Without objection that will be done.

Senator DONNELL. Dr. Baehr, I observe this language on page 210 on this report of this distinguished committee:

> The direct payment for medical services by a third party, the insurance fund, introduces a fundamental disturbance in the attitudes of both the subscribers and the doctors. The patient is tempted to demand more attention than he requires. Still more serious is the temptation of the practitioner to add to his income by rendering unnecessary service. The financial rewards for volume and the pressure of patients constitute a combination of influences which to many is irresistible. This has been the recent experience in New Zealand, and it has been our own experience in the operation of workmen's compensation insurance.

Doctor, are you familiar with the experience in New Zealand? Have you studied that?

Dr. BAEHR. We have had reports from persons who have had such experience, and there is on page 210 a footnote giving several references to reports on the racketeering by physicians that developed in New Zealand under the operation of the program which they have had in operation in that country in recent years.

Senator DONNELL. The note at the bottom of the page 210 on that citation reads:

> See the Lancet (London), December 2, 1944, page 723; see also the statement in the New York Times, October 7, 1945, by Quentin Pope, Medical Rackets Grip New Zealand.

That is correct, is it not?

Dr. BAEHR. Yes, sir.

Senator DONNELL. Now, Doctor, the report proceeds:

> We in the United States do not know how best to develop such medical insurance. We lack experience not only from the actuarial angle but also from the service angle. We have no basis in our own experience on which to estimate what the contemplated extensions in medical service are likely to cost. We do not know from your previous experience that under national compulsory medical insurance, even as the general level of medical practice is lowered its costs are raised.

Do you concur, from your knowledge, with that statement?

Dr. BAEHR. That has been true of the experience in other countries. It is particularly true now in the recent experience in New Zealand.

Senator DONNELL. The report continues on page 211:

> A system of compulsory national medical insurance presages the establishment of a vast and costly administrative machine. It would from the outset burden the practice of medicine and the provision of medical care with an overhead of many times its present size, and unlikely to yield benefits in any degree commensurate with its cost. As long experience with such public undertaking discloses, administrative machinery of this kind tends inevitably to expand and grow more costly. An equivalent sum of money spent on more modest undertakings, less burdened with machinery, might easily produce quicker and superior results, and also avoid several of the grave risks which such an overall plan creates.

Does your observation of the development of bureaucracy in this counrty tend to confirm, generally speaking, your view that administrative machinery tends inevitably to expand and grow more costly?

Dr. BAEHR. That is true, although that is not the most important consideration that I have in mind.

Senator DONNELL. What is the most important one you have in mind, Doctor?

Dr. BAEHR. The fact that the medical services cannot be delivered, in the manner in which we expect them to be delivered in return for the tax which would be levied upon each individual, we are sure that in the absence of any experiments in medical services which would teach us how to provide competent medical services in return for prepayment—in the absence of any such experiments and the gradual development of workable schemes, a national compulsory scheme coming upon us at one time would cause a tremendous dislocation in medical practice and a rapid deterioration in medical standards throughout the country.

Senator DONNELL. Now, Doctor, this report refers, in what I have just read, to certain grave risks which such an over-all plan—to quote the report—creates. Now, I observe that the report continues:

> Among these risks is the trend toward centralization in systems of social insurance, observable in the experience of foreign countries and even in our own relatively young experiment with social insurance started in 1935. In the beginning the authorities usually make or promise concession to local and State governments, and to local opinion and sentiment, both because there are obvious virtues in local adminstration and local responsibility and, also, because granting such concessions is the most effective way of stilling opposition to the plan.
>
> Before long the central or national authorities become irked by the limits on their powers, ascribe every difficulty and problem to the existence of decentralized administration, and begin to press for the nationalization of the whole system of social insurance, or of each of its parts. Since the National Government holds the purse strings, the national officialdom soon has its way.

Doctor, have you observed in various phases of public contribution there has been an emphasis on proposed legislation as regards the benefits of local autonomy? The point is made here, however, that the tendency toward a grasp of power by a national authority sooner or later becomes evident. Have you noticed that?

Dr. BAEHR. Yes; but I think the most important consideration here is that medical services are local services which develop within a community. The entire philosophy that we have been convinced is correct is that we can improve medical services throughout the country only by providing assistance from Federal and State sources to the local communities to improve those services which are local.

Senator DONNELL. That is the theory of this S. 545 bill as you understand it; is it not?

Dr. Baehr. As I understand it; yes. We must build medical services for the people from the bottom up, not from the top down.

Senator Donnell. Then you agree with the language in the excerpt which I have just read that "there are obvious virtues in local administration and local responsibility" as applied to medical matters, do you?

Dr. Baehr. Yes.

Senator Donnell. Now, Doctor, the report proceeds along this line:

> As compulsory insurance becomes established, other features of universal compulsory insurance tend to be accentuated and magnified. More and more decisions are made in accordance with a body of formal rules.

I pause to ask you if you have ever seen that volume, which I would say roughly is from 2 to 3 inches in thickness, of the rules and regulations that exist under the British system? Have you seen that?

Dr. Baehr. Yes; I have seen that.

Senator Donnell. It is quite a very bulky volume and it involves many rules and regulations.

Dr. Baehr. I have seen it.

Senator Donnell. Continuing with the report:

> Individuals and problems are treated in bulk and the administration becomes progressively depersonalized.

I pause to ask you whether or not in your opinion the personal relationship between a physician and his patient frequently has an important bearing on the success or failure of the physician's treatment of that patient?

Dr. Baehr. It certainly does.

Senator Donnell. And a depersonalization of the administration would or would not be regarded as advisable by you?

Dr. Baehr. A certain amount of depersonalization may be desirable under certain circumstances.

Senator Donnell. But, generally speaking, a scheme which destroys the personal relation or decreases the personal equation between the patient and his physician you would not regard as advisable, would you?

Dr. Baehr. That is correct.

Senator Donnell. You would not regard it as advisable, would you?

Dr. Baehr. It should be preserved as far as possible.

Senator Donnell. That is, the personal relationship between the physician and his patient. Is that right?

Dr Baehr. Yes.

Senator Donnell. Further in this report:

> Even in England, which, compared to the United States, is a small and homogeneous country, the dominance of rules is firmly established in the administration of compulsory health insurance.

They cite a volume here: T. S. Newman and A. G. Lee, National Health Insurance Manual, London, 1934. You have seen that volume, have you not?

Dr. Baehr. We have that in our library.

Senator Donnell. It is quite an extensive volume, is it not?

Dr. Galdston. Yes.

Senator Donnell (reading):

> The same conclusions, expressed even more strongly, were reached by A. M. Simons and Nathan Sinai in their study of European experience with compul-

sory health insurance. They say: "Administrators are naturally and necessarily concerned with questions of efficient economy and effective mass action. They seek standardization to insure smooth-running administrative machinery. They aim at results capable of statistical expression and that will make a 'good showing' in annual reports. In spite of the emphasis social workers place upon 'case work,' insurance society administrators approach the medical problem from the wholesale social side."

Do you concur with those observations, Doctor?

Dr. BAEHR. Yes, sir. That is quite apt to happen.

Senator DONNELL. The report then continues: "Together with rules and bulk treatment goes standardization." There is a footnote appended to the report reading as follows from Levy's book:

> A revealing experience was quoted by Dr. Morgan in a recent House of Commons debate: "I had a series of patients with artificial openings for the discharge of waste products. I had five of these patients. Some had malignant growths, others gunshot wounds, and so on. I prescribed cotton wool for these people to clear themselves up with. I was visited by a ministry of health doctor, who queried whether I had the right to prescribe cotton wool in cases of this kind and I should use tow. This is a thick fibered substance, the sort of material you make mats out of; cotton wool is a thing you put on as wound dressings. I asked him if he would care to use tow for himself under such circumstances, and he replied that that had nothing to do with the question, and that I should have saved the Exchequer money rather than prescribed the use of cotton wool."

I pause, Doctor, to ask whether tow is used by surgeons in this country or whether cotton wool is used?

Dr. BAEHR. I never heard of tow being used in this country.

Senator DONNELL. Continuing with Dr. Morgan's experience:

> "I was a member of Parliament. I told him to go to his minister * * * and that I would do what I could to fight the point." This episode deserves more than casual attention. It shows that the panel doctor may be between two fires.

What is a panel doctor?

Dr. BAEHR. A physician on a local panel from which the insured select their doctor.

Senator DONNELL. That is a panel doctor under the plan followed in England?

Dr. BAEHR. Yes, sir.

Senator DONNELL. Continuing with the quotation from Mr. Levy's book:

> He may be accused of giving patients less service under national health insurance than he would give to private patients, while, officially, he may be reprimanded for giving them more than the barest and crudest necessities. The inspecting doctor in this case would in all probability have been quite prepared to state that the application of tow would, in his view, be an "entirely satisfactory" solution.

Now, Doctor, I have here this book on National Health Insurance, A Critical Study by Hermann Levy, issued by Cambridge University Press, 1944, and ask you if the matter I have been quoting is from this document by Mr. Levy?

Dr. BAEHR. I recognize it; yes, sir.

Senator DONNELL. Now, Doctor, the report of the New York Academy of Medicine, committee on medicine and the changing order continues:

> The mere size of the national compulsory enterprise and the unavoidable preoccupation with an infinite number of details, checks, and balances, force even farsighted and competent administrators to fall back upon generalized solutions of individual, personal problems. Nowhere is this more clearly reflected than

in the subordinate position of preventive medicine under social insurance systems. Here again, in the initial stages of social insurance the primacy of preventive measures is recognized and methods are designed to deal with them; but the pressure to distribute more and more benefits, or in medical insurance to make available more extensive curative treatment, becomes too strong and prevention is subordinated to other and seemingly more urgent considerations. Hence many social insurance plans develop swiftly and imperceptibly into systems of organized relief.

Do you concur with that general statement, Doctor?

Dr. Baehr. I am sure that that is the case.

Senator Donnell (reading):

> These observations seem to be confirmed by foreign experience. Simons and Sinai write: "When insurance systems are being urged upon governments, one of the strongest arguments offered is that improvement in general health will follow prompt, universal medical care. After the system has been adopted one of the most amazing things to the outside observer is the almost complete absence in the vast volume of discussion of any reference to public health in relation to insurance. * * * At no point has the disappointment been greater than in the failure of insurance as a preventive measure."

Then the report continues:

> Such a consequence of an experiment designed to improve the health of a country would, of course, hinder and not advance the state of the nation's health. This is, indeed, one of the great risks and dangers of compulsory national health insurance.

Do you agree with the last few statements I have been reading, Dr. Baehr?

Dr. Baehr. Yes.

Senator Donnell. Including the statement:

> Such a consequence of an experiment designed to improve the health of a country would, of course, hinder and not advance the state of the Nation's health. This is, indeed, one of the great risks and dangers of compulsory national health insurance.

Do you agree with those two sentences?

Dr. Baehr. Yes.

Senator Donnell (reading):

> The magnitude of this risk is suggested by the course of mortality from degenerative diseases (and their growing importance in the total national mortality rate). Dealing with this question in his discussion of the future of preventive medicine in the United States, Dr. E. J. Stieglitz points out: "Individualized constructive medicine for adults, and particularly for senescents, should become a significant element in future preventive medicine. The control, prevention, and retardation of the common and increasingly significant degenerative diseases can be accomplished only by * * * individual attention. Wholesale or public health measures are utterly useless."

Do you concur in the observations of Dr. Stieglitz?

Dr. Baehr. Yes, sir; because they are dependent upon the early recognition of diseases.

Senator Donnell (reading):

> The risks and dangers of centralized administration constitute one of the critical problems of compulsory national medical insurance.

I pause, Doctor. You understand that S. 545 does not contemplate national medical insurance, but contemplates grants of aid to the States. That is your understanding of the bill, is it not?

Dr. Baehr. Yes, sir. I am quite clear on that.

Senator DONNELL. Then I continue with the report:

> But they are matched in importance and difficulty by numerous questions relating to the total cost of such insurance on a national scale, the way in which these costs will be distributed, the effects of alternative methods of distribution on different elements of the population, and the future trend of costs. Though the subject has been under discussion for many years, it cannot be said that anything like reliable estimates of costs are today available, and they are not likely to be for some time to come. For the risk against which it is proposed to insure the people of the United States is still unmeasured, if not unmeasurable.

Do you agree with the statement in the last sentence?

Dr. BAEHR. Absolutely. There is no question at all.

Senator DONNELL (reading):

> It would take great discretion to define the term "adequate medical care." Depending upon how this discretion is exercised, the size of the risk may be expected to fluctuate within wide limits. These uncertainties about the size of the risk will necessarily be further intensified by the influence which compulsory insurance will itself exert upon the risk.

I take it that may refer to the tendency of people to think they need treatment when they don't need it if they get it free. Is that right?

Dr. BAEHR. And the tendency of some doctors to render more services than the case demands, when they are remunerated by a fee for every service.

Senator DONNELL. Continuing further:

> Whether costs go up or down, whether the risk is magnified or reduced, will depend to a considerable degree upon the behavior of the beneficiaries. Under compulsory insurance—at least so universal experience testifies—this behavior may be depended upon to add to, not subtract from, the risk.

Do you concur with that last statement beginning "Under compulsory insurance" and ending with the words "the risk"?

Dr. BAEHR. I most certainly do.

Senator DONNELL. Now, I promised a little while ago to mention the matter of cost; we referred to it briefly here, but I read further from the report. By the way, was this report concurred in by every member of this committee, Doctor?

Dr. BAEHR. They all received it and there was no dissent on the part of anyone. The meetings were attended by the great majority of the committee, all of the meetings were.

Senator DONNELL. That is the 120 meetings?

Dr. BAEHR. Yes. After the conclusion of the report, there were several resignations from the committee of persons who in the final analysis did not support the conclusions, but with those few exceptions, there was no disagreement on the final report.

Senator DONNELL. In other words, of the 50 persons on the committee.

Dr. BAEHR. Dr. Galdston would like to make a statement.

Dr. GALDSTON. I think, Senator, it is rather desirable to know how this program and report was organized. Each section as it was originally drafted was presented to every member of the committee. Then meetings were held in which criticisms were made note of. That section was then rewritten containing the language of the criticism that was made and was then resubmitted, and if there were other criticisms to be made, they were again taken into consideration and the text modified and finally, the third time, the material was submitted to a vote and it was voted on. So that every single section as well as the document as a whole was considered, deliberated upon, modified, and finally accepted.

Senator DONNELL. Now, gentlemen, either one of you may answer this, if you please. This chapter of the report, which chapter is entitled "Medical Insurance, Voluntary and Compulsory," to how many members of the committee was that submitted?

Dr. GALDSTON. Every member.

Senator DONNELL. That would be approximately 50 members of the committee, I believe—48 of them; 2 having resigned, and nobody expressed opposition to the report on medical insurance as it appears here in its final form. Is that right?

Dr. BAEHR. That is right.

Senator DONNELL. Now referring to cost, page 215 of the report continues:

> Some idea of the magnitude of cost may be derived from various estimates of the over-all cost of all of the benefits and services, including all forms of medical benefits, afforded by the Wagner-Murray-Dingell bill. The estimates of annual costs differ by some $3,000,000,000, as the following tabulation shows, and this is taken from Mr. Earl E. Muntz' Proposals for Health, Old-Age, and Unemployment Insurance, which I hold in my hand, at this moment, issued by the American Enterprise Association, Inc., as National Economic Problems, No. 418. Continuing with the report: These costs are estimated to exceed the cost of benefits and services provided by the earlier Wagner-Murray bill of 1943 to the extent of $625,000,000.

May I interrupt the reading of this report to read this one sentence from Mr. Muntz' report. This is National Economic Problems, No. 418, appearing on page 64:

> The social-security program, as set up in this bill, would require a Federal subsidy, based on the most conservative estimates, in excess of 50 percent of the total annual expenditures.

I take it that means, by Federal subsidy, money paid out of the Federal Treasury. Don't you so understand it, Doctor?

Dr. BAEHR. Yes, sir.[1]

Senator DONNELL. Now, going back to the report:

> The increase is due to the provision in the later bill of additional benefits, the major items being $350,000,000 for dental care, $52,000,000 for nursing care, and $107,000,000 for hospital grants and loans. In any case they are initial estimates and as such they furnish little clue as to what the experiment will cost 5 or 10 years later.

Doctor, I want to pause at this point and ask you whether or not your general knowledge conforms to this observation which appears in a volume entitled "Social Security, Past, Present, and Future," by Gerhard Hirschfeld, director, Research Council for Economic Security, 105 West Monroe Street, Chicago 3, Ill. I quote from page 34:

> In Germany, compulsory health insurance was in effect in 1885, when the average illness lasted 14 days. By 1932, the average illness lasted 29 days, or more than twice as long. During this period, medical costs per insured person rose more than nine times. Although the rise may have been justified, the possibility of malingering should not be dismissed lightly. In an effort to stop the increase of sickness claims, the Reichstag decreed an extra payment of about 10 cents for prescription and consultation. At once, costs dropped by one-fifth.

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[1] Subsequently Dr. Baehr submitted the following statement: "These estimates from four different sources are 'of the over-all cost of all the benefits and services afforded by the Wagner-Murray-Dingell bill' (S. 1055), not only for the medical benefits. See Medicine in The Changing Order, p. 215."

Does your general knowledge concur with Mr. Hirschfeld's observation as to the increase, even though you don't know the exact statistical figure, but is it a fact there was a material increase in Germany between 1885 and 1932 in the medical cost per insured person?

Dr. Baehr. Yes; conversely better and more adequate medical care will tend to lower the total number of services that are required. That has also been the experience with Workmen's Compensation Insurance.

Senator Donnell. But you do concur, as I understand it, with the point made by Mr. Hirschfeld as to the increased medical cost per insured person in Germany under compulsory health insurance?

Dr. Baehr. That is correct.

Senator Donnell. Now, Doctor, I will not continue in further detail except on one or two very brief quotations. On page 216 of the report is this language:

> For a variety of reasons the cost, large as it is at first, is bound to increase.

Do you concur with that view?

Dr. Baehr. There is no doubt about that.

Senator Donnell. Referring to page 217, the last paragraph:

> The common belief that compulsory social insurance is merely a device for spreading existing costs is not supported by the facts. Cost will rise in social insurance, in general, and in compulsory medical insurance, in particular.

Do you concur with that Doctor?

Dr. Baehr. I think much more; yes.

Senator Donnell. There is one further quotation which I desire to call to your attention; it is on page 218 and 219:

> The problems which compulsory national medical insurance engenders appear so formidable, and the evils it threatens so plain, that the committee strongly advises against hasty action. Once the country commits itself to this type of policy and legislation, it cannot retrace its steps. Valuable and promising experiments to solve the problems in other ways will be abandoned because everyone will be busy setting up a massive new administrative machinery and distributing huge funds. The long record of experience in foreign countries shows that the problem and difficulties encountered in administering these plans are rarely disposed of satisfactorily. When they are dealt with at all, it is usually by means of a patchwork of amendments and executive orders which rarely go to the roots of the trouble. "Insurance institutions are usually built in haste and patched ever after."

Doctor, this is a book entitled "The Law of National Health Insurance." by Henry Lesser which, together with its index, constitutes 1,281 pages, with some flyleafs likewise numbered. Is that a book that you are familiar with and which is in your library?

Dr. Baehr. I believe that is the book.

Senator Donnell. It contains the National Health Insurance Acts of 1936–38, with explanatory notes, reported cases, decisions of the Minister of Health, and statutory rules and orders, with a foreword by the Rt. Hon. Walter E. Elliot, Minister of Health. Then, Doctor, the report of your committee continues:

> The Committee believes that medical insurance is one of the essential requirements in solving the problem of medical care distribution. It agrees that compulsion by Government would accelerate the extension of insurance to all the people. It agrees, also, that voluntary insurance will spread only slowly and incompletely among the low-income families. It is at the same time convinced that voluntary insurance provides flexibility for local initiative and is designed to encourage new and better methods of organized medical services, such as

> group medical practice, within the physical and personnel limitations of each area. It conceives voluntary insurance as an essential experiment in prepayment, which avoids the pitfalls of compulsory insurance. For these reasons the committee believes that everything should be done, by way of grants, subsidies, and employers' contributions, to hasten the growth of voluntary medical insurance.
>
> With the evidence of inadequate and unequal medical care so definitely established, it is a natural reaction on the part of the public to demand an immediate corrective. It is also in the American manner to attempt to do this by legislation. Far from being an immediate and sure solution, this radical method is rather a leap in the dark; the results are at best uncertain—may even be disastrous, and in any event are irrevocable.
>
> The recommendation made by our committee envisages the development of a slower but much surer program. It is our conviction that if such a plan can obtain the understanding and cooperation of the public, the profession, and the Government alike, it will much more surely lead to the desired goal, the distribution of comprehensive medical care of a high quality of all the people. It is thus that the great progress in medicine has been achieved in the past, and it is thus that continuance of the progress can best be assured for the future.

Now, Doctor, do you agree with that finding of the committee of approximately 50 persons as set forth in this book?

Dr. BAEHR. Absolutely.

Senator DONNELL. That is all.

Senator SMITH. Senator Pepper, do you wish to ask some questions?

Senator PEPPER. Yes. Dr. Baehr, first, as I have the figures before me as submitted in the hearings held by this committee on S. 1606, the figures show that the cost of medical benefits under the British Health Insurance Act have steadily diminished from 1921 to 1938. Do you dispute that?

The figures that I put in the record at that item show the cost of medical benefits per insured in 1921 were 14 shillings 9 pence; in 1922, 13, and so forth; in 1923, 12; 1924, 12; 1925, 12; 1926, 12, and so forth. The last year I have here is 1938, when it was 12 shillings 2 pence, whereas in 1921 in was 14 shillings 9 pence.

That shows a diminution in the cost of medical benefits per insured person. Is your information covering that period, 1921 to 1938, to the contrary?

Dr. BAEHR. Yes. Quoting on page 216 in the volume of Medicine in the Changing Order:

> In England, there has been a continuous rise in the cost of health insurance benefits per member, so that, while 12,787,000 insured received but $85,438,000 in 1920, the little over 14,000,000 insured in 1929 received $142,579,000.

Senator PEPPER. We wouldn't argue the accuracy of the respective figures, but I call your attention to page 1931 of the National Health Program, the report of the hearings on S. 1606, part 4, in which I give what I was advised were official figures.

Dr. BAEHR. Would you be good enough to give me the source of that so that we can look it up later?

Senator PEPPER. Gladly. Great Britain Exchequer and Audit Department, National Health Insurance Fund, Accounts 1917–38.

Doctor, do you concede, if they could be provided in a proper way, that it would be desirable that the services contemplated by the Murray bill should be afforded to the people who are the beneficiaries of that service?

Dr. BAEHR. The question is, sir, whether the services could be provided.

Senator PEPPER. If they could be provided in the proper way, do you agree that the services contemplated in the Murray bill are desirable for the people?

Dr. BAEHR. I think the premise that they can be provided is entirely in error.

Senator PEPPER. I am not asking you that. I want to get at the basic question of the need for the kind of services provided in the Murray bill. Do you affirm or deny that there is a need for those services by the people?

Dr. BAEHR. There is a need for additional medical services by the people.

Senator PEPPER. Do you deny the fact that the people need the services in the Murray bill?

Dr. BAEHR. They need the services.

Senator PEPPER. Let's start with that premise: They need them. Now then, the calculations that are made as to the cost of that plan, then, are based upon how much it would cost to furnish those needed services to the people.

Dr. BAEHR. That is not the entire part of the picture, as I see it.

Senator PEPPER. How do you arrive at the figures on page 215 of your report?

Dr. BAEHR. These are not our figures. These are quotations from a variety of estimates and studies.

Senator PEPPER. That is your statement, is it not?

Dr. BAEHR. Not ours.

Senator PEPPER. I mean these are the figures—let's put it this way—based upon the sources that the committee had available as to how much it would cost to render to the people the services contemplated by the Murray bill.

Dr. BAEHR. We think that the cost would be even greater.

Senator PEPPER. Even greater than that? Now then, would services be provided to the people if you gave the same services contemplated by the Murray bill in any cheaper way than the Murray bill provides for their distribution?

Dr. BAEHR. It is not cheapness that is in question, but efficiency.

Senator PEPPER. I am not asking that.

Dr. BAEHR. I think the services that would be given wouldn't be worth what the people of this country paid for them.

Senator PEPPER. Do you know of any cheaper way that the same volume of services could be afforded to the people than the plan provided by the Murray bill?

Dr. BAEHR. Yes, sir.

Senator PEPPER. A cheaper way?

Dr. BAEHR. Good medical service, no matter what you pay for it, is cheap, but poor medical service, no matter how little you pay for it, is expensive.

Senator PEPPER. I am asking you whether the same number of visitations of patients, the same number of hospital cases, the same number of surgical cases, and so forth, contemplated by the Murray bill, could be afforded to the people in any cheaper way than the Murray bill contemplates.

Dr. BAEHR. I can only tell you, Senator, that I think, and I don't believe I am unresponsive when I reiterate that what you are offering isn't cheap, that the way the Murray-Wagner bill will provide the services, no matter what the total cost, will be expensive in comparison with what the people will receive.

Senator PEPPER. That would mean that the doctors and the hospitals wouldn't give the kind of care necessary. That would be a condemnation of the doctors rather than the system.

Dr. BAEHR. Oh, no. It is a condemnation of human nature, not the doctors.

Senator PEPPER. It could be the practitioners of the system. What I am trying to get at is this: Here you come along in this report and tell us that the services provided for by the Murray bill are needed by the people, and you give us estimates above $11,000,000 as to how much they will cost. Then the Taft bill, which you in general approve of, provides $200,000,000 as the Federal contribution and holds out the hope of adequate medical service to all the people of this country, as it says in its declaration there, "without regard to race or economic status."

Dr. BAEHR. That, I assume, is its ultimate objective. It doesn't expect to do it in 1 year.

Senator PEPPER. It wouldn't accomplish it, would it?

Dr. BAEHR. I think it will accomplish it sooner than the Wagner-Murray bill. In my opinion, which is supported by the studies of the committee on medicine and the changing order, it will take vastly longer to reach the objective that we both have in mind, than by the same method proposed in S. 545.

Senator PEPPER. Would the Taft bill authorize as many people to get into a hospital as the Murray bill?

Dr. BAEHR. Not at this moment.

Senator PEPPER. All right; would it authorize as many visitations by doctors of sick people in their homes as the Murray bill?

Dr. BAEHR. Not at this moment.

Senator PEPPER. Would it make as many nurses available to sick people as the Murray bill?

Dr. BAEHR. It depends on the availability of nurses.

Senator PEPPER. Would it make as much medicine available to sick people as the Murray bill?

Dr. BAEHR. It will make more medicine of a sort available, but, with it all, Senator, there will occur, we are convinced from our own experience, a deterioration of medical standards, so that you may get a wider distribution of medical services but of a poorer quality, with a resultant deterioration of the health of the people in this country.

Senator PEPPER. You have heard the old saying, "Any old port in a storm." We may have to accept a choice between a poor doctor and no doctor at all. In that case, have you anything to say as to which your choice would be?

Dr. BAEHR. Yes. You propose to tax the people for things that you can't deliver, because there aren't the doctors and there aren't the nurses and there aren't the institutions and the required reorganization of medical service. The required reoganization of medical services will require time and experiment.

Senator PEPPER. Now, Doctor, you give us the basis upon which we can address ourselves. You say there are not enough hospitals, then, for the Murray bill to be in effect. Is that correct?

Dr. BAEHR. That is right.

Senator PEPPER. All right. How many hospitals did we build during the war for all purposes for the armed services and every other form? Do you have any information as to that?

Dr. BAEHR. I couldn't give you the answer to that.

Senator PEPPER. Do you, Doctor, have that information?

Dr. GALDSTON. No; but I would like to comment later on the nature of that question.

Dr. BAEHR. Civilian hospitals?

Senator PEPPER. I am not talking about civilian hospitals. I am talking about hospitals for the armed forces.

Dr. BAEHR. The Army built a great many.

Senator PEPPER. Yes, in a very short time, and we equipped them, too; didn't we?

Dr. BAEHR. Yes, sir.

Senator PEPPER. Literally, I should say, thousands of hospitals of one sort or another in every camp, Army and Navy. There was some kind of hospital built that served the needs of those men in the service, wasn't there? You shake your head, Doctor.

Dr. GALDSTON. I know I shake my head, but I don't think it is true. What you forget, Senator, when you say that, is that facilities for those Army hospitals were drawn away from the civilian population. We staffed them with doctors that were taken away from rural districts, from towns and other places.

Senator PEPPER. Just a minute, Doctor. I have a right to ask you to confine yourself to one question. Let's talk first about the physical aspects of hospitals; then we will talk about the doctors.

Dr. GALDSTON. That was true of the physical——

Senator DONNELL. Mr. Chairman, I object to the constant interruption of the witness. I think the witness can answer the question.

Senator PEPPER. All I want to ask and I insist——

Senator DONNELL. Just a minute. Mr. Chairman, the question has been asked and the witness has not been permitted to answer.

Senator PEPPER. May I ask the Senator to refrain from interrupting because all I want to ask is a certain line of questions about certain things.

Senator DONNELL. Mr. Chairman, I again object.

Senator SMITH. Senator Pepper, I don't think it is fair. You are trying to make it appear that the witness is supporting theories which you are——

Senator PEPPER. I merely want to confine the discussion to one question at a time. You can finish any time. I don't intend to interrupt you, but I want to confine the question at present to the physical facilities, and I am asking if you know how many hospitals were built during the war for all purposes. Do you have any information about that?

Dr. GALDSTON. Senator, you didn't ask me that. You asked me why I shook my head and I am trying to tell you why I shook my head.

Senator PEPPER. You shook your head at the time I asked whether or not there was a hospital at each Army and Navy camp. You shook your head and I turned to ask you, "Do you deny that?"

Dr. GALDSTON. You didn't say that.

Senator PEPPER. I apologize. What I want to ask is if you have any knowledge as to the volume of physical facilities provided during the war. Do you have any knowledge?

Dr. Galdston. No.

Senator Pepper. We can get that, of course, from the Army, Navy, and Public Health Service.

Senator Donnell. Just a minute. If the witness desires to amplify his answer, he may do so.

Senator Pepper. Do you have some objection to my interrogating Dr. Baehr in order to allow Dr. Galdston to testify at the present time?

Senator Smith. We have asked these gentlemen to come here as our guests and give testimony on their approach to this subject, and I think they should be treated as guests here and not interrupted in trying to state their position. Dr. Galdston has been trying to state his position. I think he is entitled to do it. I don't want to interfere with your examination, but I think that the witness is entitled to state his position.

Senator Pepper. Did we interrupt the Senator from Missouri in his interrogation of the witness?

Senator Smith. I don't think the Senator from Missouri was doing what it seems to me at least you are trying to do here—lead the witnesses along to conclusions they obviously don't agree with by putting your questions in that way. Just give them a chance in a general question to state their position. That is fair.

Senator Pepper. I now await, at the direction of the Chair, your making any statement you care to make and then thereafter I will proceed with the inquiry I was beginning to make. You may go ahead, as far as I am concerned, Doctor.

Dr. Galdston. Senator, I don't want you to think I am belligerent, but I think you extended me the courtesy by asking me why I shook my head. You implied that we produced this large number of hospitals, and so forth, the exact number of which I don't know, just out of resources that heretofore had not been tapped. The fact of the matter is that it was a short blanket that was drawn over the head and uncovered the feet. That is the real situation we face at the present time. That is what I wanted to contribute to the discussion.

Senator Pepper. Is it a fair observation to make, Doctor, that with the productive capacity of the United States of America, our ability to build buildings and to manufacture equipment, we can build a great many hospitals and furnish a great many hospitals in a rather short time if we determine to do so?

Dr. Baehr. Yes; but we could not staff them, we could not provide the medical services for them, and that is a most important part of the job.

Senator Pepper. Now we are confining ourselves to the physical facilities, as I suggested a few minutes ago. As I say, with the productive capacity of the United States of America, we could build a great many hospitals and furnish those hospitals in a relatively short time, if we determined to do so.

Dr. Baehr. Sure; you could build the structures, if you are determined to do so.

Senator Pepper. Very well. So that we can build and furnish a great many hospitals in a reatively short time, if we determine as a Nation to do so.

Dr. Baehr. But that would not solve the major problem of medical care in this country.

Senator Pepper. That is another aspect of the problem and, of course, an important one. So you say that we have to train more doctors and train more nurses in order to put the Murray bill into effect.

Dr. Baehr. That is one more part of it. That is one additional part of the medical need, but what is more important than anything else, and that is the thing I have tried to emphasize in my testimony thus far, is that you don't know as yet how best to render comprehensive medical services under prepayment. We know how to render limited or fractional services in a hospital, surgical, or even medical service in hospitals under a prepayment plan, but we do not know how to render that most important part of medicine—services to people in their homes and in doctors' offices, including consulting and diagnostic services, which are the most important in the prevention of sickness and in the early recognition of illnesses. That most important part of medical care we don't know, and we will not know how to provide, until we have experimented with comprehensive medical care under prepayment as in the experiment in which we are engaged in New York City. Our present difficulties in setting up such experiments arise because we do have not the interest or the support of Government. And these experiments, I feel, Senator, must come first and we must have Government support through grants-in-aid. We must work from the ground up. We must learn how to reorganize our medical forces and strengthen them in the various localities, so that they may function efficiently under a prepayment plan. This cannot be done without a certain amount of Government support to assist local efforts. And for this reason, Senator, we endorse S. 545.

Senator Pepper. Doctor, how could we train a good many additional doctors and a good many additional technicians and a good many additional nurses if we provided the money and we determined on a training program to that end in this country?

Dr. Baehr. It would take you a generation or more to do it. We would require more medical schools or larger schools and faculties. This would require direct Government support to medical schools. It would also be necessary to develop medical training programs for the post graduate years. This cannot be accomplished by the passage of Nation-wide compulsory health insurance. That we know full well from the experience of other countries. You have to do the required job over a period of time and in accordance with well-thought-out State plans. And that is why we favor experimentation in the building up of local resources by means of grants-in-aid to the States out of general tax funds.

Senator Pepper. Doctor, you stated in the beginning that the need already existed.

Dr. Baehr. Yes, and I have previously stated that even Senate bill 545 is deficient in that it does not provide for extension of medical education and post graduate training.

Senator Pepper. So then, if we were going to try to provide to meet the need which you have testified exists, it would certainly require a large hospital building program with all the equipment, of course, that the hospital requires.

Dr. Baehr. Ultimately, as you acquire the trained doctors.

Senator Pepper. It would require a large doctors' and technicians' and nurses' training program, would it not?

Dr. Baehr. Which would take a generation or more.

Senator **Pepper**. Now the sooner we start in an all-out way to build those hospitals and to train those doctors and technicians and nurses, the sooner we will have them, will we not?

Dr. **Baehr**. The reverse may be true. To build the hospitals without adequate staffing will merely provide shells which do not render proper medical service.

Senator **Pepper**. Doctor, I think we would all agree that the facilities would have to be operated and used by somebody.

Dr. **Baehr**. By local communities without doctors?

Senator **Pepper**. No. I mean by technicians. I mean by doctors and technicians and nurses.

Dr. **Baehr**. Living in the local community.

Senator **Pepper**. Doctor, I say hospital facilities have to be used by people.

Dr. **Baehr**. That is right.

Senator **Pepper**. Now we can be clear about that, I am sure. I agree that we will, of course, have to have qualified people to use these facilities. It is no good to have a scalpel if you don't have the doctor to use it, but I am asking whether it is not a fact that during the war, with the public nurses training program, we trained a large number of nurses who would otherwise not have been trained?

Dr. **Baehr**. Yes; we did that as a war effort, but where are they today? They are not serving the people for the most part. We have a greater shortage of nurses than we ever had before.

Senator **Pepper**. Maybe it is due to the fact that the people don't have the money to pay $7 or $8 a day which the ordinary nurse charges.

Dr. **Baehr**. No. There are also many other factors in that. Of course, that would take us a bit astray, but there are many factors involved in that situation.

Senator **Pepper**. Doctor, all I am saying is that the theory upon which the Murray bill is predicated is what seems to me to be a common sense theory, that we start out with great medical needs of the people and we are trying to solve and to meet those needs in some proper way, and those needs are to be met essentially by the physical facilities and by trained people who have the ability and the faculty to use those facilities, and then those facilities and those people and their needs have to be brought together in some way, and the bridge that is necessary to make it possible to cross the chasm of disability to afford those facilities and those services is correction of the inability to pay on the part of the masses of the people. So consequently, this, the Murray approach, is to say that people are dying every day and people are having their futures impaired every day; they are losing work every day because they don't have access to hospitals. They don't get the necessary drugs; they don't have doctors and nurses, and believing that human life is sacred and human health is important, it feels that a great country like America can do a great job in this field by going boldly ahead.

Now then, it balances. You see the problem from the viewpoint of the defects which would develop under the Murray bill. Maybe the Murray bill, if it can see the defects which exist under the present system and the inadequacies, will still exist under the Taft bill and may take the defects in, too.

You say, yes, there would be a great deal larger volume of physical facilities available and medical care available but the quality would deteriorate. So what we have to decide is: Is it in the balance of the interest to see which is in the public welfare? That is what it essentially comes down to, isn't it?

Dr. BAEHR. Yes, Senator, but if you will pardon my using the privilege of a doctor to make a diagnosis, I mean no disrespect by it, but it appears to me that, although your argument sounds plausible, you and the proponents of the Wagner-Murray bill, to my mind, seem to have a blind spot, a very big blind spot, for they fail to appreciate how serious can be that deterioration in medical services that can occur by the sudden application of a Nation-wide compulsory scheme, taxing all the people of this country and guaranteeing them in return for that medical service which they are not going to get in their lifetime.

Personally, it is my own feeling that this constitutes fraud upon the public. Furthermore most serious deterioration of medical services will occur unless there is organization at the local level of those services by trial and experiment. With Federal and State help we must build from the ground up. I don't know whether all members of my committee are in agreement with me but I believe that some day we shall reach the point where a national program of medical insurance can operate successfully. But we can't do it now and we cannot do it in this generation.

Senator PEPPER. But there are a lot of people who are going to die in the meantime.

Dr. BAEHR. No, sir. More people would die under national compulsory health insurance than die now if it were enacted tomorrow. Of that I am convinced.

Senator PEPPER. Now, Doctor, do you know of any country in the world which once has adopted a national compulsory health insurance principle—there may be; I am asking for information—but has discontinued it?

Dr. BAEHR. They cannot discontinue it, once it is adopted, no matter how bad it is. That is why I would rather see this country build up steadily and progressively to an objective of high standards of medical care for all the people.

Senator PEPPER. Then you don't know of any case where it has once been put into effect and has thereafter been discontinued?

Dr. BAEHR. Because you can't do it. Once you have completely destroyed the private practice of medicine, you can't restore it again; thereafter, all you can do is to patch and patch. They are about to patch in Great Britain.

Senator PEPPER. I am entitled to ask you to answer yes or no. Do you know any country where it has once been tried but has been discontinued?

Dr. BAEHR. No. I think it is impossible to discontinue it.

Senator PEPPER. You gentlemen have all this data at your fingertips. Do the Scandinavian countries have this national compulsory health insurance system in effect?

Dr. BAEHR. They have. In addition, they have a private practice of medicine which people buy, if they can afford to, on top of what they are paying for national compulsory health insurance.

Senator PEPPER. But do they have a national health insurance system?

Dr. BAEHR. Yes.

Senator PEPPER. Does that include all the Scandinavian countries?

Dr. BAEHR. I believe it does.

Dr. GALDSTON. Denmark, Sweden, and Norway.

Senator PEPPER. New Zealand has it.

Dr. BAEHR. Yes; much to the sorrow of their people.

Senator PEPPER. Does Australia have it?

Dr. GALDSTON. They are not all comparable. You have covered them all with one title, but they are not all comparable. New Zealand has an entirely different system than the Scandinavian countries.

Senator PEPPER. The British put a comprehensive system into effect last year. They have enacted the law for it.

Dr. BAEHR. That is right. They have enacted the law.

Senator PEPPER. And that is an extension of the system which the British have had in the past.

Dr. BAEHR. It is an extension; yes. It is an extension of the panel system to include the entire family and to include hospital, diagnostic, and laboratory services. Of course, in England, you see, you have a situation analogous to what we would have if we conducted an experiment in one State. But we are dealing with 48 States, with many different kinds of people living under many varieties of economic circumstances.

Senator SMITH. Doctor, excuse me, but I understand you would be glad to see an experiment in a State, if any State is willing to take the chance of trying it.

Dr. BAEHR. The committee on medicine and the changing order has so clearly stated that it would be delighted to see an experiment in compulsory health insurance in some State if, at the same time, there were comparable voluntary experiments in other States, which would reveal the best ways of organizing at the local level the medical services necessary to give the people what they are paying for.

Senator SMITH. In other words, you would be interested in having a guinea-pig experiment with the controls as in your medical practice, trying that and comparing it with another system beside it to see which was the more effective.

Dr. BAEHR. That is correct, and we assume, Senator Smith, that S. 545 permits that.

Senator SMITH. That is the purpose of S. 545, to permit the different kinds of experiments in different States.

Senator PEPPER. May I proceed?

Senator SMITH. Go ahead; yes, sir.

Senator PEPPER. But, Doctor, Australia is a large country geographically, isn't it?

Dr. BAEHR. It has a small population that has to be served. It also hasn't got the complexities of this country.

Senator PEPPER. And the British altogether constitute a population of over 40,000,000.

Dr. GALDSTON. May I make a correction and say that Australia has really not got a compulsory national health service and can't be put under that category.

Senator PEPPER. I say the British people, after all, are over 40,000,000, aren't they?

Dr. BAEHR. Quite right.

Senator PEPPER. Do you know what system the Canadians have?

Dr. BAEHR. They have different systems in different provinces. They do not have the same system in any two provinces. In Saskatchewan a compulsory health insurance system is being installed. They have a different system of rural medical care in Manitoba, and they have no system at all in other provinces. Canada permits just what S. 545, in our opinion, contemplates: Freedom to experiment with whatever system seems feasible within each province and meets the needs of the local areas within the province.

Senator PEPPER. Doctor, you have examined the last version of the Murray bill introduced this year, have you not?

Dr. BAEHR. The one that has just been introduced?

Senator PEPPER. Yes.

Dr. BAEHR. I haven't seen it as yet.

Senator PEPPER. Under that bill, there has been a great deal of decentralization brought about in the administration of the law. While there is a Federal board contemplated, nevertheless, each State is free to submit its own plan and to administer the plan as it thinks is the wise way to do it, and then each medical association, I believe, on a county basis is allowed to determine whether they will participate on the basis of fee for service or on the basis for a period of time or some other basis. So it would seem to me that that bill is striving for the same kind of State experimentation based upon the predication of the compulsory insurance principle which the President recommended, as the Taft bill contemplates.

Dr. BAEHR. May I comment on that?

Senator PEPPER. Yes.

Dr. BAEHR. The joker in that is that every person in the United States would be taxed and in return every person must theoretically receive free medical care. The doctors are free to choose the method of remuneration. We can assure you that if the medical profession is given that choice, at least 95 percent, as in New Zealand, will choose the only form of medical practice they know, which provides a fee for every individual service. This country will immediately witness a most scandalous situation quite like that which is happening in New Zealand. It should be much more easy to control medical racketeering and subscribe abuses in that small country than it would be in this great country. Yet the situation which has developed is catastrophic. Here we would expect to witness a multiplication of professional services and a deterioration of medical practice, which once under way would be very difficult to reverse.

Senator PEPPER. Doctor, wouldn't it be possible, do you think, either by legislation or by rules of the medical association or by public opinion pressures and criticisms, to improve such a situation should it develop?

Dr. BAEHR. No. I don't think you can improve human behavior by legislation. The late lamented Volstead Act proved that you can improve only by education of the medical profession and the public through trial and experience. I am convinced that if we will permit the doctors to experiment with voluntary medical insurance in local areas and encourage and help them in their efforts with a device such as S. 545, that you can gradually educate the medical profession by demonstration that there are better forms of medical service than the existing methods of solo practice of a fee for service basis.

Senator Pepper. Do you think that position is seriously questioned now, that a great deal could be done that is not being done?

Dr. Baehr. S. 545 with certain modifications could be used as the instrument for experimentation upon which could be built better methods of medical service that will function well and deliver efficient medical service to the people under prepayment. As we learn, we can apply this experience to larger groups of people. The happy experiences of one State will soon be accepted and imitated by another State. This would be far better than having medical chaos suddenly forced upon us by one over-all national scheme adopted with the vague hope that out of the confusion, in the course of time, something might eventually come that would work.

Senator Pepper. Now, Doctor, under the Taft bill, there would simply be a Federal appropriation of $200,000,000 that would be a grant-in-aid to the several States and they could take that money and work out plans by which they could give to people the medical services which they could not afford. That is the gist of it; isn't it?

Dr. Baehr. No. I am sorry, Senator, you were not here when I made a statement, in which I proposed certain amendments to S. 545.

Senator Pepper. I read your statement after I arrived.

Dr. Baehr. First of all, I feel that the purposes of the bill as stated in section 2 of paragraph "B" and "C" need to be implemented by strengthening the bill in such a way that a national council under the administrator or under the Director of Medical Care Services has the right to prepare certain medical standards which the grantee States would be obliged to meet. The grants-in-aid could then be used effectively to elevate the standards of medical care in the medically underprivileged States and assist the localities in building up and organizing their medical services to meet the needs of the people more effectively.

Senator Pepper. The point of it is, though, Doctor, that what the bill has the effect of doing is simply to appropriate some Federal money to enable the States to give medical service to some people who are not able to pay for it. Isn't that what it boils down to?

Dr. Baehr. As I pointed out, that part of the bill is ambiguous. It could be interpreted in that way. In the preliminary statement which I read at this hearing I advocated that the bill be reworded so that there should be no doubt that it is not a charity measure, merely a measure to provide some medical services for indigent persons.

Senator Pepper. Then you are at variance with the author as regards the purpose of the bill, aren't you?

Dr. Baehr. I don't think so. I think the author of the bill has perhaps not stated it clearly enough. We urge that the bill clearly state that the services be made available to the people in the following categories:

1. The indigent, for whom the local, State, and Federal Government must provide the entire cost;
2. Those whose low incomes permit only partial payment for comprehensive medical care; and
3. Those whose incomes are higher than category 2 but are inadequate to pay the entire cost for superior medical care.

It should be clearly stated that the object of section 711 is to assist the States to provide superior medical services at low cost through prepayment to all persons of low income in all three categories.

Senator PEPPER. Doesn't that boil down to your saying that this is to enable the States to provide, by gift, medical care to people who can't afford it?

Dr. BAEHR. Not by gift any more than the Wagner-Murray-Dingell bill makes a gift.

Senator PEPPER. The difference is that under the Murray bill, they are all required to contribute a portion of their income. Well, Doctor, you have stated a rather dismal prospect, it seems to me, in saying that for a generation it would be impossible to afford the need of medical services to the country, to the people of this country. I respect your opinion and the sincerity of it, but I just say it is a dismal prospect for the future.

Dr. BAEHR. Senator, I do not see it your way. We should do something immediately. I think the most effective method is the one proposed in S. 545 with the amendments we have proposed. I am not pessimistic at all. I think we can prove by demonstration that we can develop medical services that will function satisfactorily under prepayment and that we can steadily extend these services through the industrial as well as rural areas of your country.

Senator PEPPER. But do you affirm that you will be able to meet the need?

Dr. BAEHR. Ultimately, yes.

Senator PEPPER. I am not saying ultimately. I am saying you know the need is a matter of the moment, and what I have never been able to understand is how you doctors, and I submit that I have as much right to be sincere in this as you do—what I see is the suffering of people, and what I can't for the life of me reconcile in my mind is how you doctors, who see it every day with startling horror, can raise your voice against a program which may have error in it but which will use the genius and might of America to try to save the lives and the health of the people.

Senator SMITH. Doctor, we will have to adjourn the hearing, because the bell you just heard is the quorum call for the Members of the Senate. In behalf of the committee, I want to thank you sincerely and your associates for coming here and giving us your testimony. I deeply appreciate it and it will be of great value to the committee.

Senator MURRAY. Before we adjourn, in reading the testimony of Dr. McCormick, of the American Medical Association, who testified here yesterday, I noticed a point that he made regarding voluntary programs providing comprehensive care and I quote:

> that physicians realize that any general program of this type will be impossible to establish with a good quality of medical care.

I understand that to do exactly what the doctors speaking for the AMA say is impossible. I would like to request, Mr. Chairman, that this committee invite those groups known as the Health Insurance Plan of Greater New York, Group Health Association here in Washington, and Group Health Insurance, Inc., of New York City, to send representatives here to testify on this point. If the Chairman will agree, I will make arrangements to have someone speaking for them appear here to testify.

Senator SMITH. How many witnesses will be involved?

Senator MURRAY. Probably one from each group.

Senator **Smith**. I would be very glad to cooperate with you in trying to arrange for that. We want to get all the testimony.

Senator **Murray**. I don't want to prolong the hearings at all. I want to cooperate in every way, and I will promise you that if they come, we will probably need only 10 minutes from each one of them.

Dr. **Baehr**. May I make a statement? As far as the Health Insurance Plan of Greater New York is concerned, I happen to be a member of the board of directors of the plan, and my statements are in part based upon the observations that I have made in the course of that early experiment.

Senator **Smith**. As I said earlier in this session today, I know Dr. Dean Clark very well who Dr. Baehr said is the executive of that.

Dr. **Baehr**. He is the medical director.

Senator **Smith**. I asked him if they couldn't come down. His board doesn't want him to testify at the hearings, but they are perfectly willing to have him send a statement of what happens there for the record, and I will have it filed when I receive it. If there is no further business this morning, we stand recessed until 9:30 tomorow morning.

(Whereupon the subcommitte adjourned at 12 noon until Friday, May 23, 1947 at 9:30 a. m.)

# NATIONAL HEALTH PROGRAM

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**FRIDAY, MAY 23, 1947**

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met, pursuant to adjournment, at 12 o'clock noon in the committee room in the Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Smith, Donnell, Murray, and Pepper.

Senator Smith. The committee will please come to order. Continuing with the hearings on S. 545, on our opening day, Wednesday, May 21, we heard from the Senator from Ohio, Mr. Taft, who is the principal proponent of the bill, and we also heard from the American Medical Association. Yesterday, May 22, we heard from the New York Academy of Medicine group, Dr. Baehr and his associates, who were here and presented some of the views of their committee on medicine in the changing order.

Senator Donnell. Mr. Chairman, may I ask your indulgence in this connection to read into the record two short paragraphs from the report of the New York Academy of Medicine's Committee on Medicine in the Changing Order appearing respectively on pages 226 and 230 of said report?

Senator Smith. You may.

Senator Donnell. The first paragraph at page 226 reads as follows:

> The committee believes that voluntary prepayment plans are much safer and more adaptable than compulsory insurance, the consequences of which are at best uncertain and are in any event irrevocable. It is convinced that if a program of voluntary insurance can obtain the understanding and cooperation of the public, the profession, and the Government alike, it will more surely lead to the desired goal. It is on a voluntary basis that the great progress in medicine has been achieved in the past, and it is thus that continuance of progress can best be assured for the future.

The paragraph on page 230 reads as follows:

> In acknowledging Government participation as a reality which will probably be greatly expanded, the committee strongly recommends a general method of grants-in-aids as the one that has stood the test of American experience in the past, presents the least difficulty and disadvantage for the present, and holds the brightest promise for the future.

I thank you, Mr. Chairman.

Senator Smith. Thank you, Senator. This morning we are going to hear witnesses on the so-called Blue Cross Plan and the experiment in Michigan with the Blue Cross program. I will ask first as a witness Mr. J. Douglas Colman of the Associated Hospital Service in Baltimore, Md. Mr. Colman, will you take the stand, please.

Senator MURRAY. Mr. Chairman, I regret very much that I shall be able to remain only a few minutes because I am on the Labor conference. The meeting is going on.

Senator SMITH. Senator Murray, we regret that you cannot be here, but we wish you success in your efforts on the other committee.

Senator MURRAY. Thank you very much. I am doing everything I can to save the situation for the country [laughter]. We must have the other point of view on everything, and that is the reason I have always been so generous to Senator Donnell who represents the opposing point of view [laughter].

Senator SMITH. It is splendid that we can all keep our sense of humor at different times and have an atmosphere of friendly coöperation in trying to get legislation passed which would be helpful to our country.

Senator MURRAY. I think it cannot be denied that we have made a contribution to the solution of this great problem for the American people, no matter what the final results may be, and I want to say that I have always been sincere and honest in the way in which I have presented the matter from my standpoint.

Senator SMITH. We do appreciate your cooperation, Senator.

Now, Mr. Colman, before you present your statement, will you briefly state your biography, so to speak, your background and your qualifications as a witness?

## STATEMENT OF J. DOUGLAS COLMAN, REPRESENTATIVE, BLUE CROSS COMMISSION OF THE AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.

Mr. COLMAN. For the record, my name is J. Douglas Colman, director of Maryland Hospital Service, Inc., the Blue Cross Plan serving Maryland, and lecturer in public health administration, Johns Hopkins University. I appear as the representative of the Blue Cross Commission of the American Hospital Association.

Senator SMITH. May I just ask at this point whether you yourself have made a study of the Blue Cross movement all over the United States so that you feel you can speak on the progress that has been made and give us the testimony on that?

Mr. COLMAN. I was first responsible for administering the Blue Cross Plan, Senator, when there were approximately 50,000 participants, and I have continuously been responsible for the administration of the Blue Cross Plan since that time.

Senator SMITH. Your statement tells us how it has grown. That appears in your statement. Are there any further questions before Mr. Colman begins his testimony? All right, sir, you may go ahead.

Mr. COLMAN. The Blue Cross Commission is the national coordinating agency for 88 Blue Cross Plans by which 27,000,000 Americans place hospital care in their family budget. These 88 Blue Cross Plans operate as independent corporate entities. They are members of the American Hospital Association, of which the Blue Cross Commission is a part. Their services to subscribers are guaranteed by 3,500 member hospitals of plans in 46 States, the District of Columbia, Puerto Rico, and 7 Canadian Provinces.

Blue Cross Plans are nonprofit, community service agencies through which the public, hospitals, and medical profession unite to make hospital care readily available to all who are self-supporting as to the other necessities of life.

In 1944 and in 1946, representatives of Blue Cross Plans appeared before Senate committees to suggest that the most productive role of the Federal Government in the field of health and medical care would be to encourage and support existing, worthwhile, local efforts—to supplement them, when necessary, but not to supplant them. Therefore, we endorse Senate bill 545, and urge its passage.

This testimony will focus upon three major topics:

1. Definition and scope of Blue Cross Plans;
2. Specific accomplishments of Blue Cross Plans, and a discussion of certain recent developments which indicate their continued virility and increasing potentiality for public service; and
3. Comment upon certain provisions of the bill with which Blue Cross Plans are directly concerned.

No attempt is made to discuss certain important phases of the bill with which our concern is less immediate, such as those dealing with the organization structure of the proposed National Health Agency.

Undoubtedly you will hear more about that from other sources.

First, the definition and scope of Blue Cross Plans: Each Blue Cross Plan is a nonprofit corporation governed by a board on which are represented to the public, the participating hospitals, and the medical profession of the State or community in which the subscribers are enrolled. The members of the governing board of a Blue Cross Plan receive no remuneration for their service—just as trustees of a university, hospital, or church. Their only reward is the satisfaction which comes from a job worth doing and well done.

Senator Donnell. I notice in your mimeographed statement that each Blue Cross Plan is a nonprofit corporation governed by a board. In other words, each one of these Blue Cross Plans is a corporation organized under the laws of some State. Is that right?

Mr. Colman. Yes; of the State in which it operates.

Senator Donnell. And it is thereby subject to whatever supervision the laws of that State may afford.

Mr. Colman. That is correct. I will discuss that a little further, Senator.

Senator Smith. And every one of them is a nonprofit organization?

Mr. Colman. Yes, sir. The administrative functions of Blue Cross Plans are discharged by salaried employees working under policies determined by the governing board.

Subscribers join through their places of employment, or through some other defined segment of the population. Regular and equal payments are accepted from subscribers and used to provide hospital service for those requiring care. In 53 of these 88 Plans, hospital care is supplemented by coordinated, medically sponsored plans for medical and surgical care. In most cases the Plans are administered by the same personnel.

Senator Donnell. Just a second, Mr. Colman. The Blue Cross Plan here in the District of Columbia is organized as a corporation also, is it not?

Mr. Colman. It is organized under specific authorization of Congress. It is a corporation; yes, sir.

Senator Smith. Apparently the whole Blue Cross program is under the general coverage of the American Hospital Association. Is that right?

Mr. Colman. As to approval of standards, yes, sir; as to administractive direction, no; they are corporate entities in which the policies are determined by the individual boards of directors. The American Hospital Association can give leadership by enunciating a policy but cannot in any way force the accepance of that policy.

Senator Smith. Is there a central national Blue Cross organization that in a sense is a clearinghouse for the activities of all these organizations?

Mr. Colman. Yes, sir. That is the organization which I represent, the Blue Cross Commission, which is a part of the American Hospital Association.

Senator Smith. Then you really are representative of the American Hospital Association——

Mr. Colman. That is right.

Senator Smith. Which in a sense coordinates the activities of the Blue Cross Plans, and you have got the information which enables you to determine which plan is most successful and can give us the benefit of the whole picture. In other words, there is a Nation-wide set-up, then, that is studying this thing in order to make the service more effective year by year. Is that right?

Mr. Colman. Yes, sir.

Senator Smith. All right, thank you.

Mr. Colman. Now the cost of hospital plan membership is approximately 75 cents a month per person, or $2 a month per family. Subscription charges for medical and surgical care of hospitalized illness are approximately the same. As one would expect, these charges vary throughout the country, depending upon the services provided and the general cost level in the particular area.

By agreement with some 3,500 voluntary hospitals, Blue Cross subscribers receive benefits expressed in terms of hospital service rather than cash allowances. Typically, these benefits provide for care in semiprivate accommodations and include the hospital services necessary for diagnosis and treatment of hospital bed patients. They are available to each member of the family, usually for 3 or 4 weeks of "full coverage" with extended periods of care available at rates lower than the hospital's usual charge for such service.

To earn the right to use the Blue Cross symbol, a Plan must comply with the standards establishd in the approval program administered by the trustees of the American Hospital Association. These include nonprofit operation, free choice of hospital and physician, hospital guaranty of service benefits, representation on the governing board of public, hospital, and medical interests, and the establishment and maintenance of financial reserves adequate to protect the interests, both of subscribers and member hospitals. In addition, most Plans are supervised by some State agency, usually the State department of insurance, and in most States must comply with the statutory requirements provided for in legislation specifically applying to such Plans.

Table I attached to the testimony records the phenomenal growth of Blue Cross enrollment during the past decade. Two Plans were in operation as early as 1933.

Senator SMITH. When did you become connected with that work?

Mr. COLMAN. Late in 1934.

Senator SMITH. Almost from the beginning.

Mr. COLMAN. Yes, sir. In January 1937 there were only 534,000 subscribers. Last year, when we testified before this committee, we reported 21,000,000 participants, and you will see in table I that it totals now 26,916,342; that is April 1, 1947, and if you want to talk about today, I am sure it is almost 27,000,000.

Senator SMITH. Mr. Colman, do you find that that sort of rolls along, because when one group finally succeeds, the people come along, or do you have to have solicitors out all the time to get the membership coming in?

Mr. COLMAN. All Blue Cross Plans have field representatives who are salaried employees. They receive no commission or bonuses. Their responsibility is to explain the Plan to people who are interested in joining. Yes, we have a field staff. I will discuss some of the elements of the growth as we go along, Senator. Of that 27,000,000 who are Blue Cross subscribers, 25,000,000 are residents of the United States.

In table II, you will find the enrollment in the various stages broken down in terms of percentage of the population. Also in table II you will find them classified in accordance with the other sections of the continent, Canada, and Puerto Rico.

Senator DONNELL. Mr. Colman, the 27,000,000 Blue Cross subscribers—they include subscribers elsewhere than in the United States, do they not?

Mr. COLMAN. Yes. Within the United States there are 25,147,000. That is shown on the second page of the table.

Senator SMITH. And the remainder are mostly in Canada?

Mr. COLMAN. They are mostly in Canada; yes, sir.

Senator DONNELL. Then the percentage of population enrolled in the United States as of April 1, 1947, is 19.74. Is that corect?

Mr. COLMAN. That is correct, sir. I think by now it is probably over 20 percent. Things don't stay the same very long in Blue Cross enrollment.

Senator DONNELL. While we are on this question of percentage, I notice from table II that there seems to be quite a considerable variation, however, in percentage of population enrolled as regards the respective States, ranging in Rhode Island from 68.47 percent down to 0.62 percent in South Dakota—that is to say, less than two-thirds of 1 percent of the population of South Dakota and over two-thirds of the population of Rhode Island. Do I correctly interpret the table?

Mr. COLMAN. That is correct, sir.

Senator DONNELL. Take, for instance, New Jersey. That seems to have 24.13 percent of the population enrolled.

Mr. COLMAN. Enrolled in the New Jersey plan. My guess is there are quite a few residents of New Jersey who are also enrolled in the New York plan, because they commute to New York City and they would be listed under New York, but there is a variation by States, of course, Senator. It depends on a good many things. The length of time in which the plan has been in operation is the obvious first consideration. Some of these Plans are very new. Plans in South

Carolina and one other State have not actually started enrollment as yet.

Senator Donnell. Well, is the enrollment largely confined to the cities?

Mr. Colman. No, sir; it is not. I think it is fair to say that in the urban areas there is probably a heavier percentage of enrollment than there is yet in the rural areas, because we haven't yet learned all that we need to know about rural enrollment, but now that we have built up the question of volume to an important segment of the population, we are concentrating on the density of enrollment.

Senator Donnell. I have been searching this table for New York State. Is New York listed?

Mr. Colman. It is right under the District of Columbia, with 34.83 percent.

Senator Donnell. Now you get down to Oklahoma. It is only 9.31 percent; Arizona, 7.60.

Mr. Colman. Arizona happens to be a very recent Plan. I think it has only been in operation about 3 years.

Senator Donnell. Two States are not served at all by the Blue Cross: Arkansas and Mississippi. Is that right?

Mr. Colman. That is right. I understand there is a plan in the process of formation in Mississippi and will probably be in operation this year.

Senator Smith. The net result seems to be, however, that in about 14 years, you have moved from just about half a million subscribers—

Mr. Colman. That is in 10 years.

Senator Smith. Yes—to about the 27,000,000 today, and I take it that in these States where there are the small percentages, it is just a matter of not having gotten your work under way as effectively as you did in the States with the larger percentages.

Mr. Colman. Like everyone else, Senator, we faced a manpower problem during the war, and a training problem.

Senator Smith. I am rather surprised by my own State of New Jersey. It seems to show a little less than 25 percent, whereas Massachusetts, which has about the same population, shows close to 50 percent.

Senator Donnell. Have you observed that Missouri has 27.04 as compared with 24.13 in New Jersey?

Senator Smith. I was hoping the Senator from Missouri wouldn't notice that his State is beating my State in this important matter.

Senator Donnell. That is only to be expected.

[Laughter.]

Senator Smith. Well, you can continue, Mr. Colman. We are in a jovial mood this morning, and I have no objection to that. I think to keep an atmosphere of lightness is very nice.

Mr. Colman. Here is the record of a social program which has enrolled more participation in less time than any voluntary movement in the history of the world. There is yet no indication that it is approaching a "saturation point" which, through the years, has been set at anywhere from 5,000,000 participants up. Rhode Island Blue Cross has enrolled approximately 70 percent of the State's population, and Massachusetts and Delaware now have more than 50 percent of the population enrolled. Seven other States with a total population of 34,000,000 persons have between 30 and 40 percent of their population enrolled. Most of this has happened in 10 years. Clearly the voluntary, prepayment approach to the economic problems of health services cannot be dismissed lightly as an "interesting experiment." It is a social mechanism that has gotten up a full head of steam. No secret formula produces these heartening results. Public interest and confidence are the simple ingredients. If these were augmented by the encouragement and support contained in Senate bill 545, the results would be even more phenomenal.

As I indicated earlier in the discussion of the saturation point, these results have exceeded our expectations of 10 years ago, but, like many other things with human experience, as we grow, our responsibilities grow, too.

The growth and acceptance of Blue Cross Plans have far exceeded the expectations of their enthusiastic supporters of 10 years ago. Even more rapid, however, has been the growth of the responsibilities which Blue Cross Plans are called upon to undertake as the public becomes aware of their potentialities, and I would like to review for a few minutes some of the progress we have made toward our specific objectives.

First, as far as geographic coverage is concerned, Blue Cross membership is now available to the population of 46 States and the District of Columbia. We have succeeded in securing a broad geographic coverage. Now our effort is to concentrate on density of enrollment, and we are giving increasing attention to those segments of the population not routinely accessible through the usual group channels, such as craft workers, farm bureaus, granges, homemakers' clubs, volunteer fire departments, and so forth.

Senator Donnell. Pardon me, but do you mean those who are not routinely accessible or those who are?

Mr. Colman. Those who are not routinely accessible as employed groups, and we are concentrating on that type of group.

Senator Donnell. Take the American Farm Bureau Federation. Is that one of the organizations that you are working on?

Mr. Colman. We have received admirable cooperation from them, sir. I believe we have groups enrolled in about 18 of the 21 farm bureaus in Maryland, and I think that same cooperation has been extended in your State most actively, Senator, in Missouri. The Farm Bureau has cooperated very closely with the Blue Cross and we have secured a broad rural coverage in Missouri.

As trained personnel becomes available, more plans are concentrating their effort on community-wide enrollment under the sponsorship of local citizens' committees. Other plans have undertaken enrollment programs directed toward individuals for whom no group enrollment is possible.

Senator Smith. I assume some industries have made Blue Cross Plans available.

Mr. Colman. That is our standard source of enrollment. Perhaps I didn't make that clear, Senator. That is our first effort, to enroll groups of employees through their place of employment, but you can't reach everyone that way.

Senator Smith. With the cooperation of their employer?

Mr. Colman. Yes.

Senator SMITH. Have you found that the employers are pretty cooperative?

Mr. COLMAN. Yes. In the early days, when the idea was perhaps not as well known, we occasionally had a little difficulty explaining who we were and what we were trying to do, but now that the idea is generally accepted, we have little difficulty from that source.

Senator SMITH. You had the same difficulty probably with it as the ordinary insurance salesman had until his job became appreciated.

Mr. COLMAN. I think perhaps we had even more.

Senator SMITH. Well, go ahead; I wouldn't interrupt.

Mr. COLMAN. Fifty-three of the 88 Blue Cross Plans offer complete protection for catastrophic illness through coordination with Plans for medical or surgical protection.

Senator SMITH. Let me interrupt you there just a minute, because when you speak of 53 of 88 Blue Cross Plans, that indicates to me that you don't have a Plan per State, that you may have 4 or 5 Plans within a State. Does that mean you break down into counties, perhaps, or municipalities?

Mr. COLMAN. Yes, sir. Take, for instance, the State of New York. The Plan with headquarters in New York City covers up to Astoria County in Long Island, I believe, and there is a Plan with headquarters in Albany, another in Utica, another in Syracuse, Rochester, and Buffalo.

Senator SMITH. And those Plans may vary. They don't have to be uniform, do they?

Mr. COLMAN. They do not have to be uniform, no sir. In New Jersey there is a Plan. The Plans organized in recent years have tended to be State-wide Plans. The Plans organized in the early stages of the movement were likely to be serving a natural marketing area.

Senator DONNELL. By the term "Plan," you are not using the word in the sense of a scheme or method. You are using it in the sense of a nonprofit corporation, aren't you?

Mr. COLMAN. I am talking of a specific corporate entity.

Senator DONNELL. Then perhaps it would be well to capitalize the word "Plan" in our record the same as you do here, would it not?

Mr. COLMAN. I believe so, sir.

Senator DONNELL. So that we do not become confused into thinking these are different methods.

Mr. COLMAN. Right. From other witnesses you will hear the activities of prepaid medical care plans described more fully. However, for our purposes, I think it is fair to say that, as shown in table III, which shows the enrollment in medical care Plans coordinated with Blue Cross Plans, you will find that the enrollment growth in those Plans gives promise of growing even more rapidly than did Blue Cross Plans at the same stage in their development. There were approximately 4,800,000 persons in medical care Plans as of April 1, and are probably up to 5,000,000 by now.

Senator SMITH. You mean those Plans do not include the Blue Cross Plans?

Mr. COLMAN. No, sir. Those 5,000,000 people are part of the 25,000,000 that are enrolled in Blue Cross Plans. They are the same people. These are people who have added to their Blue Cross medical care coverage.

Senator SMITH. I see. That is a supplemental coverage . I wanted to ask you later the question of coverage.

Senator DONNELL. Approximately how many did you say were in the United States?

Mr. COLMAN. Twenty-five million.

Senator DONNELL. And there are nearly 5,000,000 who have these medical and surgical features?

Mr. COLMAN. That is right.

Senator DONNELL. What do those 20,000.000, approximately, in the United States who do not have the medical and surgical features possess under the Plans of which they are members?

Mr. COLMAN. Their coverage provides for hospital care, the hospital bill, the services provided by the hospital.

Senator DONNELL. That means just the room and——

Mr. COLMAN. Room and board and laboratory services.

Senator DONNELL. Does it include intern attention?

Mr. COLMAN. Oh, yes.

Senator DONNELL. Where do you draw the line between medical facilities and nonmedical facilities?

Mr. COLMAN. In general, the services provided by surgical and medical Plans are those provided by private practitioners of medicine.

Senator DONNELL. If I may interrupt you so that I can get it clear in my mind: Here are 25,000,000 people, approximately, in the United States that are adherents of the Blue Cross Plan. Of those, 5,000,000 have the medical and surgical plans. Suppose anyone of us here this morning is one of the remaining 20,000,000 who do not have medical and surgical plans, just what would I as an individual get if I were one of the 20,000,000?

Mr. COLMAN. When you come to leave the hospital and go to the cashier's window, if you have been in a semiprivate room, you get a receipted bill.

Senator DONNELL. But I would not get a receipted bill from my doctor or my surgeon. I would get a receipted bill just for the room and the meals in the room.

Mr. COLMAN. There is a little more than that.

Senator DONNELL. And the incidental attention which the hospital gives to the occupants of rooms.

Mr. COLMAN. Last year in Maryland, not for Blue Cross subscribers, but for the general population occupying semiprivate rooms, breaking down the hospital bill into the specific items, you find that room and board is a little less than 50 percent of the total bill and the rest of the bill is made up of charges for medications and dressings and laboratory services, operating room, and so forth. Those extra charges have increased particularly by reason of penicillin, streptomycin, and things of that sort. The big increase in hospital charges in recent years has been in the extra services rather than in room and board. I just want to point out that it isn't like buying a room in a hotel.

Senator SMITH. But it wouldn't include such things as penicillin, would it?

Mr. COLMAN. Yes, sir; they are covered. The bulk of these Plans routinely provide these things to the patient.

Senator SMITH. In other words, they wouldn't have to pay those extra charges?

Mr. Colman. No, sir.

Senator Donnell. But these 20,000,000 people do not get free medical care from their doctors.

Mr. Colman. That is right, unless they are a subscriber of a coordinated medical plan.

Senator Donnell. I understand that 20,000,000 are not subscribers but that 5,000,000 are subscribers to the medical and surgical Plan.

Mr. Colman. That is right, sir.

Senator Smith. Is your Blue Cross organization working toward including medical and surgical Plans?

Mr. Colman. Yes, sir. In most cases, the medical-care Plans are administered by the same personnel that administer the Blue Cross Plans. They are, however, a separate corporate entity; their financial responsibilities are separate, and the medical profession has an increased participation in their direction because of their major interest and hospitals have less.

Senator Smith. But that would be an additional cost to the patient who gets the benefit of it in addition to the $2 a month that you mentioned in the Blue Cross Plan.

Mr. Colman. That is right. It is approximately double that. In other words, it is $2 for hospital care and another $2 for medical care.

Senator Smith. Under your Plan, you have no provision for those who are what we call medically indigent. Does your Plan cover most of the white-collar class, the medium-income group?

Mr. Colman. I do not think so, sir . If you have 70 percent of the population enrolled, as they have in Rhode Island, they can't all be white-collar workers, and many of our plans have 75 percent enrollment in specific communities and in specific industries, and that has to reach pretty far down the economic ladder.

Senator Smith. I don't want to get you off the subject here, but I would like to ask this question while I think of it: Are there any States where the States have made provision for funds to take care of the premiums for all the medically indigent people?

Mr. Colman. No, sir; not that I know of. That has been discussed in several States. The only tax funds that are routinely available for care rendered through these Plans have been through agencies such as the Farm Security Agency. They have done it with some of their borrowers. The Veterans' Administration has made administrative agreements with certain of these Plans to provide for the care of veterans in civilian hospitals for service-connected disabilities only. They are not permitted to do it for non-service-connected disabilities by law.

Senator Smith. We contemplated in S. 545, if some of the States desire it, to arrange to pay a premium for Blue Cross service containing the medical and surgical features. I am trying to think of a way to handle it so that it will reach the coverage you want it to reach.

Senator Donnell. Mr. Colman, you referred to Rhode Island, where you have an enrollment of about 70 percent of the people, and stated, of course, that not all those could be white-collar individuals. Well, what about out in California, where the percentage is only 7.34, and you have very large cities there, too? What about the percentage of adherents to the Plan in California?

Mr. Colman. I have never personally investigated the situation in California. I am frank to say I don't understand why there hasn't been more in California. There are three Plans in California, one serving the southern area, one the Bay area, and one the northern area, and their enrollment growth in recent years has given us some hope that it may pick up steam and get going.

Senator Donnell. Here is Texas. They have only 3.71 percent in Texas as compared with around 70 percent in Rhode Island. Of course, there are some good-sized cities in Texas, too—Houston, Fort Worth, Dallas.

Mr. Colman. Texas has been in operation 3 years, I believe, perhaps a little longer but not much. They started certainly during the early days of the war, and I don't think they have really had a chance to get rolling yet. I think one of the most typical States perhaps is Colorado, where, with a few big cities and few broad rural areas, they have done an excellent job, and their enrollment is not at all concentrated in Denver; it is all over the State.

Senator Donnell. There is Nebraska with only 7.42.

Mr. Colman. I don't think Nebraska has been in operation very long, Senator. You also have the question of varying degrees of public interest in the various States. The degree to which they succeed, I think, is due to the intensity of interest on the part of the citizens of the State and the hospitals of the State.

Senator Smith. You may continue, Mr. Colman, unless you have some more questions, Senator.

Senator Donnell. No.

Mr. Colman. Blue Cross Plans have initiated an effective program of Nation-wide service to subscribers. Virtually all Blue Cross Plans participate in a joint agreement whereby subscribers of one Plan may transfer to another Plan without loss of benefits accumulated by length of membership. Fortunately, this program was initiated before the war and continuity of membership was possible for many citizens whose residences changed as a result of their participation in the war effort.

Similarly, Plans have entered into a reciprocal agreement whereby the subscribers of most Plans who require hospital care away from home are eligible for the same benefits as Blue Cross subscribers in the area in which the hospital care is received.

Under the auspices of the Blue Cross Commission, a national enrollment office has been established whereby the particular problems of groups whose members live in widely scattered geographic areas can be met effectively by the individual Plans serving those areas.

Senator Smith. I notice, Mr. Colman, that occasionally you depart from your mimeographed text. I wonder if you want to have the text as a whole appear?

Mr. Colman. Just as you wish, Senator. I think perhaps it would be wise to have the entire text appear in the record and any variation from it might be noted by the recorder.

A high proportion of participation in some geographic areas and in some enrolled groups is evidence that Blue Cross subscription charges are within the ability to pay of most of the population. I think we have discussed that. There is one other point on that. Many persons enroll in Blue Cross despite their eligibility for some form of hospital care at the expense of tax funds. We frequently find some people who are in need of public assistance enrolled in Blue Cross. So that it is not limited only to the white-collar group.

Almost 70 percent of the population of Rhode Island now voluntarily participates in its Blue Cross Plan. It is not unusual for Blue Cross Plans to enroll 75 percent, or more, of the members both of employed groups and individual communities in which community-wide enrollment efforts have been undertaken. There is every reason to believe than an overwhelming majority of the population will participate voluntarily in prepayment health-service plans as the awareness of their value grows.

Employers exhibit a growing interest in Blue Cross and an increasing willingness to share a portion of the subscription charges. Particularly, in the presentation of medical-care Plans concurrently with hospital care Plans is this employer contribution helpful. In some instances it has been the stimulus necessary to secure 100-percent participation in both hospital and medical care Plans by a group of employees. Most Plans encourage this by offering added benefits for 100-percent participation.

Plans report increasing percentage of participation among their enrolled groups and decreased cancellation rates. "Ask the man who owns one" is always a good test of any product or service. It is significant, then, that the bulk of the enrollment increase in most Plans, month after month, comes from an increase in the percent of participation among groups already established. It is doubtful if Blue Cross Plans will have a more severe test than that imposed by the widespread disruption of continuous employment resulting from both military service and domestic war work. It is revealing that the few months following the close of the war did not seriously disrupt the growth pattern of Blue Cross Plans and that the enrollment increase during the first months of 1946 was higher than during any previous period in the life of Blue Cross Plans. Blue Cross subscribers are encouraged to maintain their membership when they sever their connection with the group through which they enroll and real progress has been made toward the goal stated in the slogan, "Once a subscriber, always a subscriber."

And I think that is one of our major points of difference from private insurance carriers. We feel we are trying to do a community service which requires that we look upon people as citizens of the community and not members of a single group.

Senator Donnell. Has there been any opposition manifested by private insurance carriers, as you call them, to the development of Blue Cross Plans, Mr. Colman?

Mr. Colman. No, sir; there has not. As a matter of fact, many of the home office people in the large insurance companies have been very much interested in the development of Blue Cross. They feel we are performing a useful service and we have had excellent cooperation from them.

Senator Donnell. Take some insurance company which specializes in the sale of health insurance. Do you find that it opposes the development of Blue Cross Plans or is it cooperative?

Mr. Colman. No, sir; they have not opposed it. I am trying to think of some specific instance. In many cases, executive officers of large insurance companies serve on the board of Blue Cross Plans as sponsors. I am trying to think of an instance and I can't recall one just at the moment, but I know that is a fact. John Gore, who was the senior vice president and actuary, Senator, in your home State, was one of the guiding spirits of the Blue Cross in the early days.

Widespread cooperation of employers has been received in the maintenace of Blue Cross membership of employees during work stoppages. Blue Cross Plans routinely maintain protection and defer collection of subscription charges during work stoppages.

Senator Donnell. You mean they just postpone the collection but they do not forgive them.

Mr. Colman. That is right. We haven't found it possible to do that as yet.

Senator Donnell. I don't see how you could do that.

Mr. Colman. No, sir; and in some cases we find that employers have even advanced the subscription charges for their striking employees.

Employers consistently have agreed to undertake the collection and transmission of Blue Cross subscription charges for the interim period from those returning to work, and, in some cases, have advanced subscription charges for striking employees.

Operating costs of Blue Cross Plans have been kept low despite rapid growth. The entire cost of operating Blue Cross Plans averaged 13 percent of income during the year 1946. Realizing that costs expressed as a percent of income are always high during periods of rapid growth this record becomes doubly important. During 1946, many Plans were put to considerable expense keeping track of the migrations of their subscribers at the close of the war. Thus far, administrative economies, and those resulting from increased volume, have largely offset the increases expected as a result of the increased cost of the goods and services Blue Cross Plans purchased in the discharge of their administrative duties.

Now we come to comments that we would like to make in connection with Senate bill 545.

This bill would bring into being many of the forces Blue Cross long has hoped would supplement and extend its efforts to bring more and better health service to all. We urge its passage because—

1. Its provisions permit the full use of the potentialities for public service found in voluntary Plans. Health needs are not a fixed quantity. They are ever-expanding. It is doubtful if the resources of any single agency, even the Federal Government, can keep pace with them. Full utilization of all resources is imperative to attain maximum public service. Hence we welcome the bill's challenge to State and local agencies and to voluntary plans to form an effective partnership with the Federal Government.

2. It provides the authority necessary to offer Blue Cross membership to Federal employees. An estimated 300,000 of the 2,000,000 Federal employees now participate in Blue Cross Plans. This low ratio of participation is due to the difficulties of handling subscription payments without the cooperation of the employer. This provision of the bill will make Blue Cross available to at least 3,500,000 additional Federal employees and dependents. This action will signify the interest of the Federal Government in the extension of voluntary plans to the fullest degree justified by the public interest. This action by the Nation's largest single employer will stimulate similar action by many State, municipal, and private employers not now enrolled.

Time of Federal employees consumed by present cumbersome procedures will be saved.

3. The State-wide study of health needs provided for in the bill will reveal additional and more effective uses of existing resources. In few States is there any public or private agency with official warrant constantly to compare what health services are available with what is known to be valuable and to plan systematically to repair the deficiencies. In a field as complex as the health services, planning is a necessary prelude to effective action. Also, it frequently is the stimulus of latent interests and energies that might otherwise lie dormant without the prod of local participation.

4. Federal assistance is offered in a manner which does not destroy in persons or localities their sense of ultimate responsibility. More liberal provisions for those States and those segments of the population less able to provide for their own needs is sound when offered in a way which does not offend dignity or stifle initiative. The provisions of the bill make this possible. There is a mutuality in the provision of health services. There must develop within the patient an understanding, a desire for the service, a sense of participation. The most elaborate hospital construction or the finest laboratory equipment will not alone assure effective service to patients. The most carefully calculated diabetic diet is of no use unless the patient takes it home and lives by it. He is more likely to do that if he has an interest and faith in its source. Medical care given to patients who have no faith in it, nor desire for it, is frequently wasted. Our resources for health preservation are too limited to waste.

5. Hospital construction will be made feasible in areas which could not now support a hospital if built. Few States now provide for the full cost of hospital care even to recipients of public assistance who receive all other necessities of life from tax funds. As a result, limited resources of hospitals are not fully available for service to paying patients. By carrying a portion of this load, the bill will increase hospital resources available to the entire population. In some areas this added support will permit hospitals to operate where they cannot now exist. Blue Cross cannot provide service where there are no hospitals. Hence we have a direct interest in this possibility of the bill.

Now I would like to comment on certain provisions of the bill.

It would be desirable if the funds made available to States as grants-in-aid could extend the type and amount of health services now available. It would be regrettable if funds available under the bill were matched by some form of State expenditure that is now generally accepted as a State responsibility, or for which some other Federal matching funds are now available. The committee may wish to specify in the bill some types of State and local expenditures which are not eligible for grants-in-aid under this bill.

The natural function of the Medical Care Council provided for in the bill seems to be to bring to the Federal Government the understanding and experience of persons who otherwise would have no official concern with the problems of the National Medical Care Council. However, the language on page 24 of the bill does not provide that the council consist of "persons not otherwise in the employ of the Federal Government." Such provision is included with respect to the Dental Health Council.

The language contained on pages 21, 26, and 34 of the bill, specifying that the Federal administrative agency shall not determine the methods by which States accomplish the purposes of the bill, is vital. The administrative flexibility permitted in achieving defined objectives is an essential feature of the bill. Without that flexibility one of the greatest promises of the measure is forfeit. Nation-wide uniformity of method must not be confused with universal availability of service. The language referred to above should be preserved in its entirety as Congress proceeds with its consideration of the measure. Without the specific authorization of Congress, the Federal purse should not be used to dictate local methods of administration.

Senator SMITH. May I ask, Mr. Colman, in your experience of more than 10 years connected with this movement, have you found that this diversity of method has been helpful in the evolution of your whole program?

Mr. COLMAN. It certainly has, because some of the ideas that we had in certain areas, to begin with, had proved themselves wrong and we learned how to change them and move ahead.

Senator SMITH. You don't think that an over-all blueprint for the Nation as a whole could have been laid down in the beginning which could have worked toward a successful realization of each Plan; do you?

Mr. COLMAN. I am sure it couldn't have been, Senator.

Senator SMITH. I am sure there were certain principles that had to be laid down as a guide.

Mr. COLMAN. That is my firm belief.

Senator SMITH. Continue, then.

Mr. COLMAN. We subscribe to the findings of the bill that there are inadequacies in the distribution of health services. We endorse its statement of intent to aid States in correcting those inadequacies. We remind that Blue Cross Plans exist solely to make hospital care more available to all people. We welcome the partnership offered by this bill to join in a united attack on a problem that is beyond the capacities of any single agency of society.

We take violent issue with those who feel that universal availability of service can only be attained with centralized financing and centralized control. We believe just the opposite is true. Centralized health services, or centralized anything else, tend to become self-limiting.

We know that the ever-expanding horizon of medical science and health service provides a challenge to the fullest joint effort of all agencies—Federal, State, local, and voluntary.

We urge the passage of Senate bill 545 as the most productive step which can be taken now by the Federal Government to stimulate sound progress toward our mutual objective of more and better health service to all the people.

Senator SMITH. Now, Mr. Colman, I want to ask you a few questions that occurred to me here. The first is to get it in the record again—you said it already, but let's get it in the record at this point—the coverage of the Blue Cross Plans. It isn't an over-all health coverage for all the people. It is a limited coverage to the actual hospitals.

Mr. COLMAN. It covers generally the items which are included on the bill presented by a hospital to the patient.

Senator SMITH. I see. And that does not include medical or surgical care?

Mr. Colman. No, sir.

Senator Smith. You referred to the fact that an additional Plan might cover those other items.

Mr. Colman. Yes, sir.

Senator Smith. As you conceive this whole moving picture, would you say if we could set up a supplementary plan of the Blue Cross covering medical and surgical care that we would have a program approaching an over-all health coverage, or are there still other areas now to be covered and taken care of?

Mr. Colman. In general, the medical-care Plans that have been established to date in conjunction with Blue Cross Plans provide for the care of hospitalized illness. They do not in general provide for the care of the ambulatory patient, and there is a good reason why they don't. We haven't learned much about the administration of that type of health service. Nobody knows very much about how to do that on a mass basis, and that is one of the reasons why we would regret very much seeing a Nation-wide effort made to tackle that problem at the moment, because we feel that it would freeze at a very limited stage of evolution the science of how to render that care.

Senator Smith. You would agree, then, with the feeling that I have had: That under S. 545 it is better to explore those fields and to set up plans and evolve the answer to that question.

Mr. Colman. I feel that way very strongly.

Senator Smith. And with your experience with these Blue Cross Plans, you feel that it could be very successfully done; that you do benefit one another in studying the various approaches to these questions.

Mr. Colman. Yes, sir.

Senator Smith. Let me ask you this further question, if I may. Would you say that your Plan primarily doesn't get below the income group that is represented usually by the white-collar workers?

Mr. Colman. I am sure we get well below that, sir.

Senator Smith. Of course, where you have an industrial company, with the cooperation of the employer, you can get 100 percent enrollment.

Mr. Colman. Even without the cooperation of the employer, we frequently get 80, 90 or 100 percent—without the cooperation of the employer and there is no contribution by the employer.

Senator Smith. Have you made any study as to the level of income at which people can afford to pay the premiums?

Mr. Colman. I think it is a matter of judgment. It is a question of how badly they want it.

Senator Smith. Would it vary across the country?

Mr. Colman. It certainly would. One other factor enters into it there and that is there are large segments of the population, particularly along the eastern seaboard, that have not previously paid anything toward the cost of their hospital care. They have received it free in governmental institutions.

Senator Smith. You still would expect that hospitals would serve as they have in the past, with free service, and so forth, for the medically indigent people.

Mr. Colman. Their ability to do that is increasingly limited, and the public is going to have to acquire more and more of that responsibility.

Senator SMITH. You are probably aware of the alternative approach suggested by Senator Murray in his bill which contemplates a compulsory health-insurance program with taxes to provide the funds for an over-all health coverage. If such a bill were passed, what would it do to the Blue Cross? Would the Blue Cross be of no value or use any more?

Mr. COLMAN. It would all depend on the provision of the bill; but, in general, I would say there would be little need for the Blue Cross, little excuse for its existence as a nonprofit community service, if a measure as sweeping as, for example, the Wagner–Murray-Dingell bill were passed. I have not had a chance to study the bill Senator Murray introduced a few days ago, so I can't comment on that, sir, but I understand that some of its provisions differ somewhat from his previous measure.

Senator SMITH. Is it fair to say, in your judgment, that we are facing a consideration of a difference of two points of view, one which contemplates an over-all tax to take care of everybody and the other which takes the step-by-step proposals of S. 545, which is decentralization, urging the States to develop their plans and to share Blue Cross Plans, which you have developed so amazingly from your figures, which would fit in with that State-Federal partnership?

Mr. COLMAN. I think you stated the issue, Senator, between the two opposing points of view, and I regret that the word "centralization" enters into the discussion so frequently, because that is one of those labels that gets confusing. You can take the same measure and turn it over to one administrative agency and you will end up here, and the same legislation turned over to another administrative agency will make you end up here. That is why I made such a point in my testimony about the safeguards which are included in Senate 545 as to no dictation of method. I think those are vital. That is really what we mean by centralization. It isn't who writes the check. That isn't important. It is how it is administered.

Senator SMITH. Then you would lay great stress on the word "flexibility" and "evolution" too, by experience, by trial and error.

Mr. COLMAN. I do. I think that is the essence of the issues between the two measures that you are discussing.

Senator SMITH. There are one or two more questions. Am I correct in my assumption that your Blue Cross Plans are self-supporting, that they don't require any Government subsidy? You work out your premiums on a basis, of course, that if a man can't pay the premium, he doesn't get the benefit of the Blue Cross, but under S. 545, it is contemplated that with grants-in-aid to the States, the State organization would help the fellow who couldn't pay and it would pay his premium, and he would be on the same basis as any other insured person, whether he pays it himself or whether the State does.

Mr. COLMAN. That is correct.

Senator SMITH. Would it be administratively feasible to work out a method whereby people with low incomes, who could not pay the premium, would have the State pay part of the premium? Do you think that would be possible?

Mr. COLMAN. I think it would be possible; yes, sir.

Senator SMITH. It wouldn't interfere with the machinery that you have, as I understand it.

Mr. COLMAN. No, sir. I would hope that such payment of premium could apply to categories of persons rather than any individual case decision. I think it would be unfortunate in an expenditure of such a small sum as that per person to get involved with individual case decisions. But assuming that this measure is flexible enough to apply to categories, I am sure that that could be done administratively.

Senator SMITH. There has been a good deal of discussion at these hearings regarding certain people who, aside from their ordinary living, just simply can't afford to pay the extra cost of medical service. There would be no objection in your mind, would there, to classifying possibly some income level in different areas of the country, depending on the cost of living, and so forth, at which they may be paid?

Mr. COLMAN. I see no reason why that can't be done. The Federal Government does it when it comes time to pay the cost of government.

Senator SMITH. I might say at this point that I think at the end of your testimony today it would be wise, even though there may be some repetition, to have your full consecutive statement published.

Mr. COLMAN. I hoped you would, sir.

Senator SMITH. We will do that, so that we will have your complete story. Senator Pepper has come in now, and I would like to ask him if he has some questions he would like to ask.

Senator PEPPER. Yes, I would; and about the subject generally. Mr. Colman, I have read your prepared statement. I am sorry I didn't get to hear your oral testimony. Are you familiar with section 216 of the Murray bill as recently introduced?

Mr. COLMAN. No, sir. I just got it yesterday.

Senator PEPPER. It is brief. May I call your attention to that section, which reads as follows—its title is Agreements With Voluntary Health Insurance and Other Organizations:

> SEC. 216. (a) In the provision of personal health services, it shall be the policy to utilize individuals or organizations qualified under this part to render such services, including (1) any organized group of individuals, (2) any partnership, association, or consumer cooperative, (3) any hospital or any hospital and its staff, or (4) any organization operating a voluntary health-service insurance plan or other voluntary health-service plan.
>
> (b) The State agency is authorized to enter into an agreement with any organization referred to in subsection (a) for the provision of personal health services under this title Any such organization, whether or not it enters into an agreement wth the State agency on its own behalf, shall be permitted to act as agent for individuals or other persons in negotiating or in carrying out agreements with the State agency for rendering personal health services under this title.
>
> (c) Any agreement under this section shall provide that each class of personal-health services will be furnished only by individuals (or, in the case of hospital or auxiliary benefits, by persons, as defined in sec 281 (1)) who are qualified under this part to render such class of services, and each of whom has agreed or has authorized an agreement to be made on his behalf with the State agency that he will furnish such services in accordance with this title and with regulations prescribed thereunder. Each such individual or person shall be responsible, both to the State agency and (in accordance with applicable State law) to individuals eligible for personal-health services as benefits, for carrying out such agreement made by him or on his behalf.

Now I want to call your attention to that because it would be my observation that that language specifically authorized the State agencies, and I am going to refer to them in another section, to select the Blue Cross by proper negotiation and an agreement could be arrived at between the State agency and the Blue Cross organization.

Now may I also address your attention to page 32 of the Murray bill beginning with section 241. It is entitled "Part D. State Administration, Declaration of Policy." I mention this because, as I pointed out here yesterday and to Senator Taft the day before, the public is not yet fully aware of the extent to which Senator Murray and his cohorts have decentralized the former Wagner-Murray-Dingell bill and emphasized State administration. Now I think that is accomplished partially in the section to which I am going to refer:

> SEC. 241. It is the intent of Congress that the benefits provided under this title be administered wherever possible by the several States, in accordance with plans of operations submitted and approved as provided in this part, and in each State insofar as feasible by the same State agency which administers, or supervises the administration of, the State's general public health and maternal and child health programs.

I want to read part of the next section and forego the remainder of section 242:

> SEC. 242. (a) Any State desiring to assume responsibility for the administration in the State of the personal health-service benefits provided under this title to all individuals in the State who are eligible for such benefits may do so for the period beginning July 1, 1949 (when benefits first become available under this title), or for the period beginning July 1 of any succeeding year, if it has undertaken, through its legislature, to administer such benefits in accordance with the provisions of this title and with the provisions of regulations and standards prescribed thereunder, and, at least twelve months in advance, has submitted and had approved a State plan of operations which—
>
> (1) designates as the sole agency for the State-wide administration of benefits under this title a single State agency duly authorized under the law of the State to administer such benefits within the State in accordance with the provisions of this title, the provisions of regulations and standards prescribed thereunder, and the provisions of the State plan;
>
> (2) provides for the designation of a State advisory committee which shall include members who are familiar with the needs for personal health services in urban and rural areas, and who are representative of the interests of individuals in the State who are eligible for benefits, such members to constitute a majority, and members chosen from the several professions, hospitals, and other organizations in the State by whom such benefits will be provided, to advise the State agency in carrying out the administration of such benefits in the State;
>
> (3) provides for the decentralized administration of this title in the State in accordance with part C, for the designation of local health-service areas, and for such methods of selecting the members of local advisory committees and of local professional committees as are calculated to insure representation of the nature set forth in sections 233 and 234, respectively;
>
> (4) provides such methods of administration, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Board shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Board to be necessary for the proper and efficient administration of such benefits in the State;

and so on.

So that it would seem to me as an observation which I was merely calling to your attention that a great deal of progress has been made in focusing interest in this new bill upon State administration, but it does preserve the essential thing, that the basis of the plan as the President recommended in his message is the compulsory-insurance principle.

Senator SMITH. Might I ask, Senator Pepper, whether in that statement you are trying to point out really the difference between your position and S. 545? You believe in the over-all compulsory insurance principle and we believe in the other.

Senator PEPPER. That is right. I think that is the basic difference in these bills. As the President said in his message, the heart of the national health insurance plan is the basic principle of required insurance on the part of practically all the adult portion of the population, whereas under your plan, it is entirely voluntary; the Government has nothing to do with it. You are like a cooperative. What you really are is a cooperative, isn't that right, as you stated here? You say it is a nonprofit organization.

Mr. Colman. That is right.

Senator Pepper. It is, in substance, a cooperative, like down in my State, where we have citrus cooperatives, like we have farm cooperatives; we have certain consumer cooperatives. They are all voluntary and private. Now the Taft bill approaches the problem from the viewpoint of further public assistance in the rendition of medical services, and it seems to me that that is fairly a grant system; in fact, it says a grant-in-aid system, which is a gratuitous contribution by the Federal Government to people who need medical care that they can't afford to pay.

Now there are two ways by which that is given, as I see it, and I would like to see if you agree with me about that. One way is to enable the States to do the distribution of the funds pursuant to State plans. The States may just pay outright for medical cost and medical care, including all aspects of medical care that a person may need, or they may buy a membership in a voluntary organization like yours, but there is no required system of determining how much the person should contribute, it seems to me. It is left up to the State to determine that matter, and then it overlooks the question of the medically indigent as related to the person who might on the face of things appear not to be indigent.

Now, then, do you understand the Taft bill as being substantially what I have stated or what is your conception of it?

Mr. Colman. Well, sir, the one point that I would like to make in reply to your comments about the difference between the approaches of the two measures concerns your comment about the new Wagner bill as being a decentralized effort.

Senator Pepper. Essentially, I say, emphasis is being focused on it.

Mr. Colman. I hate to see labels attached to things, and as I said just a moment before you came in, Senator, you can take the same measure, the same law, and turn it over to one agency for administration and you will get results over here. If you will take the same measure administered by an agency with a different philosophy, you will have entirely different results.

Now, when the Hill-Burton bill was passed, providing for grants-in-aid to States for hospital construction, many of us in the hospital field felt that that was a very sound move. It gave States some degree of freedom and, I understand, standards and regulations provided by the Federal Administrator, and I know in the new Wagner bill, the section immediately following the section which you read on page 18, I think it is, the next section says:

> Each agreement made under this part shall specify the class or classes of services to be furnished or provided pursuant to its terms, shall contain an undertaking to comply with this title and with regulations prescribed thereunder.

Now what kind of regulations? Under the Hill-Burton bill—I got the regulations the other day, and in reading through them, I find that when a State submits its plan under the Hill-Burton bill, as soon as possible after the award of the construction contract, the applicant shall submit to the Surgeon General through the State agency for approval a complete list in triplicate of all proposed groups 2 and 3 equipment, including an itemized estimate of costs.

Well, what is group 2 and 3 equipment? You go up a little further and you find group 3: Nondepreciable equipment of less than 5 years' life; examples, waste baskets, bed pans, and dressing jars.

It seems that is carrying Federal regulations to their ultimate extent, and when you say decentralization, I would like to have it backed up by the kind of language that I find in S. 545 which says:

> It is intended that the States shall devise in each case the method by which this end is obtained, and no plant or modification shall be disapproved because the director disapproves of the methods proposed if the program is designed and calculated to provide—

and so forth.

Senator SMITH. Would you think, Mr. Colman, with the large amount of money that is contemplated to be raised by this over-all pay-roll tax to be controlled by the Federal Government that there is a danger of increasing the tendency of the Federal Government in determining the regulations under which the plan would be administered?

Mr. COLMAN. That has certainly been my experience.

Senator SMITH. I would like to read again for the record the experience that was brought to light in this book entitled "Medicine in the Changing Order" which came before us yesterday. It is a report of the New York Academy of Medicine committee on medicine and the changing order. I quote from page 211 of this report:

> Among these risks is the trend toward centralization in systems of social insurance, observable in the experience of foreign countries and even in our own relatively young experiment with social insurance started in 1935. In the beginning, the authorities usually make or promise concession to local and State governments and to local opinion and sentiment both because there are obvious virtues in local administration and local responsibility and, also, because granting such concessions is the most effective way of stilling opposition to the plan. Before long the central or national authorities become irked by the limits on their powers, ascribe every difficulty and problem to the existence of decentralized administration, and begin to press for the nationalization of the whole system of social insurance, or of each of its parts.

Would you say from your experience that that is a sound statement?

Mr. COLMAN. I would subscribe to that; yes, sir.

Senator SMITH. I continue to quote:

> Since the National Government holds the purse strings, the national officialdom soon has its way. In time, therefore, the benefits of local autonomy—flexibility, adaptation to local needs and peculiarities, the development of local responsibility, which are strongly stressed in the initial debates over the plan, are discarded in the interest of a "neater" and more automatic scheme of administration. In his appraisal of the Beveridge plan for universal medical service in England, Hermann Levy, the author of an exhaustive review of British experience with compulsory health insurance for 33 years, concludes: "* * * It would be best to try to build up and reorganize sickness insurance in this country not from the roof but from the ground."

Would your experience and your observation be in line with that reasoning?

Mr. COLMAN. Yes, sir. I think the analogy is very much an analogy between a parent and a growing child. If you attempt to do everything for the child, protect him from the difficulties that he faces, when he reaches adult life, he is rarely able to face those challenges.

If we really are talking about developing a sense of local responsibility, we have got to give the States a chance to make some mistakes, a chance to learn how to do the job properly. We will never develop local responsibility if they say they can't do it and we won't let them.

Senator SMITH. And the alternative would be that we would turn the Federal in to the State, thereby creating a bureaucracy in the States. Would you agree with that? They would tell them how to do the work.

Mr. COLMAN. I agree with it; yes.

Senator PEPPER. But, of course, you know that what the Senator from New Jersey has said about one Federal plan could, of course, apply to another Federal plan if Congress just changed the language. So you are talking about a Federal appropriation to be made by the Congress annually which the Congress may condition in any way that it sees fit, and Congress may pass the Taft bill that had a little broader language in it. Under the Taft bill, the States are supposed to submit plans and they are required to be in accordance with a certain portion of the Taft bill consistent with its objective. But assuming there is a broad latitude in the original bill, there would be no prohibition against Congress imposing future conditions upon those funds any more than it might impose upon other funds.

Mr. COLMAN. I am not so concerned about congressional restrictions, sir. My concern is over the ingenuity of Federal administrators in interpreting the authority under which they act.

Senator PEPPER. Well, if Congress has given a relatively complete autonomy to the States under the present version of the Taft bill with supervision by a Federal agency, the next Congress might put it all under the new Cabinet officer that is contemplated who will have general charge over the whole field of health and welfare, might it not?

Mr. COLMAN. If Congress decides that is a wise thing to do, that is our democratic process, but what I am concerned is having that decision made by an administrator.

Senator PEPPER. I am quite aware of that, but, of course, an administrator can only make decisions as are authorized by the Congress.

Mr. COLMAN. That is true, but the question of what is authorized by the Congress is a question of interpretation.

Senator PEPPER. Now isn't there this difference in the two funds? The funds under the Taft bill are outright Federal appropriations, grants out of general revenues from new taxes, whereas the funds that are to be administered by the Murray bill, except any supplementary appropriation which might be contemplated under that bill, would be somewhat like social-security taxes. This might be called taxes, or call it required contributions or compulsory insurance, whatever you wish. The proceeds would be earmarked funds which would come directly from the people who are directly to be benefited to a larger percentage than are the funds that are involved in the Taft bill. Is this not true?

Mr. COLMAN. As I said earlier, sir, I only saw that bill last night and I haven't read it. I don't know what is in it.

Senator PEPPER. Now I was impressed by your statement as to the rapid growth of the Blue Cross Plans. To what do you attribute the rapid growth of the Blue Cross Plans in the United States?

Mr. Colman. I think there are three salient features. One is they meet a real public need, of which the public has become aware. They are local organizations in which the public has confidence and in which they have developed a real interest, and I think they meet a need. They have the confidence of the public and they have captured the interest of the public, and those three items are the answer.

Senator Pepper. In other words, there was a feeling of necessity on the part of the public of being able to provide by some prepayment for medical care of a certain kind that they were afraid they might not otherwise be able to obtain, and you have made it possible for those people to sort of budget certain medical care that they may require by periodic payment.

Mr. Colman. That is right.

Senator Pepper. Well now, you say that you have got 25,000,000 people in the United States and 20,000,000 in Canada who are enrolled in the plan altogether.

Mr. Colman. That is right.

Senator Pepper. Could you tell us how many of those people have the degree of what you would call complete coverage?

Mr. Colman. For hospital care?

Senator Pepper. Everything.

Mr. Colman. What do you mean by everything?

Senator Pepper. Let me specify the following: First, the visitation of a doctor to the patient's home.

Mr. Colman. Very few have that.

Senator Pepper. Very few have that. The visitation of a nurse to the patient in the patient's home.

Mr. Colman. I don't know of any that have that.

Senator Pepper. Third, the clinical examination, what we call the general check-up—the ability to go to a hospital and get a general check-up, a thorough check-up, including X-rays and metabolism tests and the general check-up that you could get if you went to a first-class hospital and said, "I want my periodic or annual general check-up." How many of them are there?

Mr. Colman. If the patient is admitted? In the first place, you get this from a physician; you don't get it from a hospital. If the physician admits the patient as a bed patient to a hospital, most Plans cover that. If he is not admitted as a bed patient to a hospital in general, that is only covered by the medical care plan.

Senator Pepper. So the majority of them, then, do not have that kind of clinical service.

Mr. Colman. I would say most of that work that is done is done on bed patients, Senator.

Senator Pepper. I am not talking about bed patients . I am talking about John Smith who works here at the grocery store and he wants to get this annual check-up, the way I try to get one by going out to Walter Reed Hospital.

Mr. Colman. I go to a doctor. He looks me over in his office and he decides whether I need any of those things.

Senator Pepper. Are you a doctor?

Mr. Colman. No, sir.

Senator Pepper. I think they go through a good many analyses to find out whether there is anything wrong with you in a general check-up. They just don't look at you and say you are all right. They go through a lot of chemical and other tests, and if you go to a private doctor, it will cost you from fifty to a hundred dollars or more. If they are going to determine whether you may have an incipient cancer in your stomach, or not, they will probably have to use X-rays and take some pictures.

Mr. COLMAN. Probably true.

Senator PEPPER. Now, can John Smith who works at a grocery store downtown and is a member of your Blue Cross Plan go in on the first of July or some other day each year and say, "I have come for my regular annual check-up. I want a thorough check-up, including X-rays and the other services that are involved in an accurate and thorough and complete medical check-up?"

Mr. COLMAN. We are now into the question of what is the appropriate content of an annual physical examination. I just don't know, Senator.

Senator PEPPER. I am just asking as a matter of fact.

Mr. COLMAN. You are talking about the kind of service that is routinely rendered in an internee office for an osteopathic or ambulatory patient. No, they are not covered by many of these Plans. A few of them do cover that.

Senator PEPPER. I understand. Now what services actually are covered? Do the majority of the people who are enrolled in the Blue Cross Plan actually get——

Mr. COLMAN. The 25,000,000 that we speak of get the services that routinely appear on the hospital bill that they would get from the hospital business office if they weren't a Blue Cross subscriber.

Senator PEPPER. Does that include the surgeon's fee?

Mr. COLMAN. No.

Senator PEPPER. Does it include the doctor's bill?

Mr. COLMAN. No. Those are the subscribers that are listed on table III of the testimony who are enrolled in the coordinated medical and surgical care plan, the 5,000,000.

Senator PEPPER. Well now, have you made any estimate, Mr. Colman, from your experience as to what it would cost a person to get under the Blue Cross Plan the kind of complete medical care that is provided for in the Murray bill, or if you don't know the latest version of it, your recollection of what was contained in the previous one?

Mr. COLMAN. If you are talking about the service available to all the citizens of the State of Maryland, for example, or the District of Columbia, there isn't any price that would provide that.

Senator DONNELL. What was that to determine, Senator?

Senator PEPPER. I meant the kind of medical care supplied by the Murray bill. I mean whether you have any estimate as to what it will cost. You mean there is no private insurance company and no cooperative that you know of today that will give you that degree of completeness in average coverage?

Mr. COLMAN. No, sir. Even the Federal Government can't buy it. There aren't doctors enough or hospitals enough or dentists enough. That is my point, Senator.

Senator PEPPER. Well, a few people who are able to pay for it at the present time are able to buy it. I can get it by going out to Walter Reed or the Naval Hospital, such as these other Senators can by going out to one of those hospitals, and many people who can buy the best medical service can get it at the present time, can they not? If they have the money to pay for it?

Mr. COLMAN. There are some areas where you can't get it.

Seantor PEPPER. What I was suggesting is: Is it fair to say that the mere fact that the Blue Cross has grown as it has, and I am very happy to say that in our report of last year we commended it——

Mr. COLMAN. You have always been sympathetic to our efforts, Senator, and we appreciate it.

Senator PEPPER. But isn't the growth of your institution a recognition of the fact that there has been in the past a great need of medical services for the people and that the people are reaching out for the best medicine available?

Mr. COLMAN. We have no quarrel on that point at all. I agree with you wholeheartedly.

Senator PEPPER. So now it gets down to a question as to the matter of degree: whether or not we should leave it, whether we should give certain aid by Federal appropriations to the States and then let them give medical care to people who, according to their standards, can't afford it, and whether we should leave it to the voluntary system such as you and others now have or whether we should try to make what we might call an all-out approach to it and require every person to make a periodic contribution into a common fund and out of that fund to pay as much of the over-all bill as the fund will pay and then supplement the rest of it, just as the Taft bill does, by Federal appropriation and try to carry out the objectives of that full and complete program.

That is where we are at the present time, are we not? And the Taft approach is the limited approach of providing $200,000,000 by the Federal Government. Out of your experience, would you say that that is likely to meet the health needs of the people in the country, that $200,000,000 from the Federal Government?

Mr. COLMAN. No; not at all, and the point that I made earlier, Senator, is that I feel that any attempt to meet the health needs of the country from a single source will eventually be self-limited.

Senator PEPPER. Well, now, Mr. Colman, I talked a little bit yesterday to the doctors who were here, and I wish we could have said some things on the record that we said off the record. Can we all agree on this? Can we all agree that we should start a program not limited by money, because I think we appreciate the health of our people, or should, more than the dollars that we have, that we should start an all-out program to train as many doctors and technicians and nurses as we can so that they may be available to serve the people of the country, and then we should provide as many physical facilities as necessary for those doctors and technicians and nurses in administering to the health needs of the people in this country? Can we agree that we ought to do that?

Mr. COLMAN. We certainly ought to encourage medical education and research.

When you get into the question of how that can be done without interfering with some of the advantages inherent in our present program, you are beyond the field that I am qualified to comment on, because medical education is a science in itself.

Senator Pepper. The reason I said that—and I want to address that question to other people who come here, and especially those who are doctors—I said to the doctors yesterday: "Surely, you want to see all the doctors that can be trained, if we have a shortage of doctors; you want to see more medical schools, you want to see more technicians trained, and so on, and why don't you come in and say: 'You gentlemen of the Congress are not doing your duty to the people of this country if you let nothing but physical limitations, not money, be the limit of what you gentlemen in the Congress do to meet this unmet need of the people of this country'." And I would like to see some of the doctors—somebody said a little while ago the labor leaders did not come in with suggestions about labor legislation. I think they are subject to criticism for not having done so, but it is very seldom that the doctors come in and tell us how many more medical schools we should have and how much money should be appropriated immediately, and how we can train thousands more doctors and more X-ray technicians and nurses and all that sort of thing. You gentlemen reproach us for our delinquencies if we are not doing everything that should be done. Maybe the Taft bill does do everything that should be done. If it does, all right, that meets all the needs that this does, but when we are dealing with a subject as sacred as life and health, should we not do everything we can do? And if that bill doesn't do it, I would like you to tell us how it should be changed. You say this bill in some respects is good, but it doesn't do this, and it doesn't provide for that and the other thing—"You are not going to take care of more than one-tenth of the people; how are you going to take care of the other nine-tenths?"

Mr. Colman. I was proud to be a part of the American Hospital Association, which I think had a leading part in putting through the Hill-Burton bill for hospital construction on just the point that you mention, physical facilities, Let us make them available. Now it is up to the Congress to make the necessary appropriations to put that into effect. Come budget time we have difficulty.

Senator Pepper. That program provides $75,000,000 a year for 5 years.

Mr. Colman. But you haven't provided that yet.

Senator Pepper. I agree with you, that has not been provided yet. Sometimes I am a little intense about this subject, but I would like people to know that I never lived in towns where there were hospitals until I lived in the town where I went to college. In the capital of my State there was no real hospital until recently, when the Army moved out of an air base and left a little hospital out there which they are now trying to run. Until that time there was only a little converted residence with, I think, 12 or 15 rooms in it, which was the hospital for the capital of my State. I have seen people die in the halls of that hospital. I have seen the most pitiful conditions with rural people coming in with dead babies in their arms, because they could not get anybody to administer medical care. So sometimes I think we ought to give a little more concern to human life and human health.

Mr. Colman. I agree with you, Senator, and you must remember that we in Blue Cross have done more about that in terms of factual accomplishment than anybody else. That is what our purpose in life is. We are trying to do just what you are talking about. The question is, how to do it?

Senator PEPPER. Thank you very much, sir.

Senator DONNELL. Mr. Colman, I was out of the room for a few minutes during your examination. When I returned you were discussing some features of the Murray bill, S. 1320. I am wondering if you have observed the provisions at the bottom of page 6 and the top of page 7, defining hosptal service?

Mr. COLMAN. No, sir; I told the Senator I had not seen that until last night. I just skimmed through it. I haven't read it.

Senator DONNELL. I am wondering if you would be kind enough to turn to those pages while we have the benefit of your presence. Although you are not a doctor, I assume from your connection with the hospital work and Blue Cross work you are familiar generally with what constitutes hospital service?

Mr. COLMAN. Yes, sir.

Senator DONNELL. I notice in this bill, S. 1320, at the bottom of page 6 and top of page 7 it is described as:

> Hospital services consist of hospitalization, including necessary nursing services, and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Board, after consultation with the National Advisory Medical Policy Council by regulation designates as essential to good hospital care, for a maximum of 60 days in any benefit year.

Now, Mr. Colman, is there a variety of practices in the hospitals of the country as to this physician, laboratory, ambulance and other services which are esesntial to good hospital care, or is there uniformity?

Mr. COLMAN. It varies all over the lot.

Senator DONNELL. You mean by that that there is a great variation?

Mr. COLMAN. Yes; for example, in ambulance alone, no hospital in Baltimore owns an ambulance that I know of. It is all provided by the fire department.

Senator DONNELL. I didn't get your last answer there, Mr. Colman.

Mr. COLMAN. For example, ambulance service. In Baltimore no hospital owns an ambulance. It is all provided through the fire department.

Senator DONNELL. So this provision in S. 1320 with respect to defining, in addition to hospitalization, including necessary services—in defining in addition to that such physician, laboratory, ambulance, and other services as are essential to good hospital care, is really an important provision; is it not?

Mr. COLMAN. I would think so; yes.

Senator DONNELL. It is very important in order to obtain the best practices throughout the country rather than having this variation which you have described as being "all over the lot," which now exists; is it not?

Mr. COLMAN. It is the same old question of trying to provide something that is not routinely available. Many things might be desirable, but if you can't find the people to render the service, you can have all the regulations you want and you won't get it.

Seantor DONNELL. I understand, but what I was getting at is that this is really an important provision. S. 1320 has a provision that gives somebody the power to prescribe what physician, laboratory, ambulance, and other services are included in hospital care. That is an important provision of the bill; you would say?

Mr. COLMAN. I certainly would.

Senator DONNELL. Now, I am wondering if you would turn to pages 38 and 39 of the bill and observe there the composition of this National Health and Insurance Board, which is given authority by regulation to designate what physician, laboratory, ambulance, and other services are essential to good hospital care. You observe, do you not, in section 251 that the National Health Insurance Board consists of five members, three of whom are to be appointed by the President, by and with the advice and consent of the Senate, and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security? You observe that; do you not?

Mr. COLMAN. Yes, sir.

Senator DONNELL. Now, you will observe a little further down, lines 6 to 8, that only one of the appointed members is required to be a doctor of medicine, the language being:

> At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States.

You observe that?

Mr. COLMAN. Yes, sir.

Senator DONNELL. So I take it that you and I would agree in the construction of the language, that with the exception of the Surgeon General, only one other member of this board of five is required by the provisions of this section to be a doctor of medicine. That is correct; is it not?

Mr. COLMAN. Yes, sir.

Senator DONNELL. And you observe no other qualifications whatsoever than are prescribed as to who the remaining members of the Board shall be, other than the Surgeon General, the Commissioner for Social Security and the one appointed member. You do not observe anything, at least in that section, that contains any qualifications?

Mr. COLMAN. No, sir.

Senator DONNELL. Now, I call your attention to the fact that the Federal Security Agency today, of which Mr. Watson B. Miller is Administrator, contains, as branches of that agency, the Social Security Administration and the United States Public Health Service. You are familiar with that fact, are you not, Mr. Colman?

Mr. COLMAN. Yes, sir.

Senator DONNELL. And that, according to the composition provided here on pages 38 and 39, this Board would automatically have two of its five members composed of individual component officials under the Federal Security Agency. That is correct, is it not; namely, the Commissioner for Social Security and the Surgeon General of the Public Health Service? You observe that; do you not?

Mr. COLMAN. Yes, sir.

Senator DONNELL. Now, you will note down at the bottom of page 39, after defining this Board and telling what its functions are, you note this language at the bottom of the page, lines 22 and following:

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

You see that; do you not?

Mr. COLMAN. Yes, sir.

Senator DONNELL. Now, the Federal Security Administrator today is Mr. Watson Miller; is he not?

Mr. COLMAN. Yes, sir.

Senator DONNELL. You know, as a matter of fact, that Mr. Watson Miller is not a physician; do you not?

Mr. COLMAN. Yes, sir.

Senator DONNELL. And yet it prescribes in here that this Board, only one member of which, other than the Surgeon General, is required to be a doctor, is to perform its administrative functions and all of its functions, so it says, under the direction and supervision of the Federal Security Administrator, who is not a doctor. You see that?

Mr. COLMAN. Yes, sir.

Senator DONNELL. Going back again to pages 6 and 7 where this Board, all functions of which are to be exercised under the direction and supervision of Mr. Watson Miller at the present time, is given authority to prescribe what physician, laboratory, ambulance, and other services in connection with hospitalization are essential to good hospital care; you observe, therefore, do you not, Mr. Colman, that the Board which determines what you have said to be an important feature of this bill; namely, that physician, laboratory, ambulance, and other services are essential to good hospital care—that Board determines that, performs all its functions, as prescribed on page 39, under the direction and supervision of the Federal Security Administrator, who at this time is not a physician, and as to whom there is no requirement of law that he be a physician. That is correct; is it not?

Mr. COLMAN. It appears so to me.

Senator DONNELL. Now, one other thing. Senator Pepper was referring to the advisability of annual check-ups. From your observation, Mr. Colman, will you say that 2 hours a year would be a reasonable estimate of the time that would be taken by a physician in making an annual check-up of a comprehensive nature?

Mr. COLMAN. I would say so, as a layman's opinion, but I think you are getting into a question there that even competent authorities will argue about, as to what should be the contents of an annual examination.

Senator DONNELL. Well, I will not pursue that further.

Mr. COLMAN. I mean you can go into that at great length, and perhaps you have observed from your contacts with hospitals about what you would think as a layman. I don't think it has any weight here.

Senator DONNELL. Very well. I will not pursue that further.

Mr. COLMAN. I would comment, though, on the point you were just making, about what services shall constitute good hospital care by saying we had a little experience with that just recently when, as a member of the Hospital Licensing Board in Maryland there was a suggestion for regulations under which laboratories would be licensed, and under the provisions of that act, which did not contemplate anything of the sort, the proposal was made to set up a board of registration whereby all the employees and all laboratories would be licensed by the State board of health, and a whole series of other items, and that was all to be done under the authority of an act licensing hospitals, and it was argued that that was necessary to assure the citizens of the State competent laboratory service.

Senator Donnell. Now, Mr. Colman, would you consider it good common sense to vest the ultimate determination of what physician, laboratory, ambulance, and other services are essential to good hospital care in a man who is not required by law to be a doctor? Would you regard that as good common sense?

Mr. Colman. No, sir; not if I had to go to the hospital.

Senator Donnell. That is what S. 1320 does, is it not?

Mr. Colman. Yes, sir.

Senator Donnell. Now, Mr. Colman, if you turn to page 36 of this bill, S. 1320, I would like to ask you just a question or two. Then I will desist. You know down at line 10 it is provided as follows—and I call this to your attention in view of the point that has been, as I inferred from what I heard when I got in, emphasized by Senator Pepper as to the attempt of S. 1320 to decentralize, turn back to the States as many functions as possible—I call your attention to this language, lines 10 to 13, page 36:

> If a State has not, prior to July 1, 1948, submitted and had approved a plan of operations, the Board shall notify the governor of the State that the Board will be required to administer this title in the State, commencing July 1, 1949.

In other words, there is that requirement that the State, in order to retain its power of operation, is going to have to prepare and submit and have approved by July 1, 1948, its plan; otherwise the Board, the National Board which is controlled, ultimately is to perform the administration of all of its functions—is controlled by a man who is not a doctor at the present time—I say this Board then notifies the governor that the State, not having submitted a plan of operations, the board, controlled as I say in its administration by this nonphysician, will be required to administer this title in the State, commencing July 1, 1949. You observe that; do you not?

Mr. Colman. Yes, sir.

Seantor Donnell. Now, you have not had time as yet to study S. 1320, except very hastily, I assume, Mr. Colman?

Mr. Colman. No, sir; I have not read it in full at all.

Senator Donnell. That is all.

Senator Smith. Are there any further questions?

Senator Pepper. Did Mr. Colman at any time, or any other person on behalf of the Blue Cross, file a schedule of fees that they charge? Did you not say in your statement, Mr. Colman, that somebody else would later go into more detail about that? I just wanted for the record to have a statement of fees.

Mr. Colman. I believe that has been filed with the committee, sir, and if it has not, I will be glad to make it available.

Senator Pepper. Would you have any objection to that, Mr. Chairman?

Senator Smith. No objection.

Senator Pepper. Will you just file that statement then of your schedule of fees?

(Subsequently Mr. Colman submitted the following schedules:)

*Tabulation of rates charged by Blue Cross Plans, July 31, 1947*

CODE: P = Contract provides private-room accommodations.
SP = Contract provides semi-private-room accommodations.
W = Contract provides ward accommodations.
RA = Contract provides cash room allowance regardless of accommodations actually used. Figure following RA (thus, RA-6) indicates the amount of cash allowance provided.

| Plan | Accommodations | Rates | | |
|---|---|---|---|---|
| | | 1 person | 2 persons | 3 persons |
| Hospital Service Corp. of Alabama, Birmingham, Ala | P | $0.90 | $1.80 | $2.20 |
| | W | .60 | 1.20 | 1.50 |
| Associated Hospital Service of Arizona, Phoenix, Ariz | SP | 1.00 | ---------- | [1]2.35 |
| Hospital Service of Southern California, Los Angeles, Calif | W | 1.10 | 2.60 | 3.30 |
| Hospital Service of California, Oakland, Calif | W | 1.10 | 2.60 | 3.30 |
| Intercoast Hospitalization Insurance Association, Sacramento, Calif | RA-5 | .90 | 1.80 | 2.25 |
| Colorado Hospital Service, Denver, Colo | SP | 1.00 | 1.90 | 2.25 |
| Connecticut Hospital Service, Inc., New Haven, Conn | RA-6 | 1.10 | 2.20 | 2.60 |
| Group Hospital Service, Inc., Wilmington, Del | SP | 1.00 | 1.90 | 2.25 |
| | W | .65 | ---------- | 1.35 |
| Group Hospitalization, Inc., Washington, D. C | SP | .65 | 1.50 | 1.75 |
| Florida Hospital Service Corp., Jacksonville, Fla | W | 1.00 | ---------- | 2.50 |
| United Hospital Service Association, Atlanta, Ga | P | .90 | 1.60 | 2.15 |
| | W | .70 | 1.30 | 1.75 |
| Hospital Service Association of Savannah, Savannah, Ga | P | 1.00 | 2.00 | 2.60 |
| | SP | .80 | 1.60 | 2.10 |
| Idaho Hospital Service, Boise, Idaho | W | 1.00 | 2.00 | 2.50 |
| Group Hospital Service of Illinois, Alton, Ill | SP | 1.00 | 1.50 | 2.00 |
| Blue Cross Plan for Hospital Care, Chicago, Ill | SP | 1.25 | ---------- | 3.25 |
| Decatur Hospital Service Corp., Decatur, Ill | SP | 1.00 | ---------- | 2.25 |
| Northern Illinois Hospital Service, Inc., Rockford, Ill | RA-3.50 | .65 | ---------- | 1.30 |
| Blue Cross Hospital Service, Indianapolis, Ind | SP | 1.00 | ---------- | 2.50 |
| | W | .80 | ---------- | 2.00 |
| Hospital Service, Inc., of Iowa, Des Moines, Iowa | RA-4.75 | 1.20 | ---------- | 2.40 |
| Associated Hospitals Service, Inc., Sioux City, Iowa | RA-4.75 | 1.20 | ---------- | 2.40 |
| Kansas Hospital Service Association, Inc., Topeka, Kans | RA-4 | .85 | ---------- | 1.75 |
| Community Hospital Service, Inc., Louisville, Ky | RA-5 | 1.00 | ---------- | 2.00 |
| Hospital Service Association of Alexandria, Alexandria, La | RA-5 | 1.00 | ---------- | 2.30 |
| Hospital Service Association of Baton Rouge, Baton Rouge, La. | RA-6 | 1.06 | 2.00 | 2.50 |
| | RA-4 | .60 | 1.10 | 1.50 |
| Hospital Service Association of New Orleans, New Orleans, La. | P | 1.10 | 1.90 | 2.40 |
| | W | .70 | 1.25 | 1.65 |
| Associated Hospital Service of Maine, Portland, Maine | SP | .85 | 1.50 | 2.00 |
| Maryland Hospital Service, Baltimore, Md | SP | .75 | 1.50 | 2.00 |
| Massachusetts Hospital Service, Inc., Boston, Mass | SP | 1.25 | ---------- | 3.25 |
| | W | .75 | ---------- | 1.95 |
| Michigan Hospital Service, Detroit, Mich | SP | 1.40 | ---------- | 3.10 |
| | W | 1.12 | ---------- | 2.60 |
| Minnesota Hospital Service Association, St. Paul, Minn | RA-5 | 1.00 | ---------- | 2.25 |
| Group Hospital Service, Inc., Kansas City, Mo | SP | 1.00 | 1.50 | 2.00 |
| Group Hospital Service, Inc., St. Louis, Mo | SP | 1.00 | ---------- | 2.00 |
| Hospital Service Association of Montana, Helena, Mont | RA-4 | 1.00 | ---------- | 2.00 |
| Associated Hospital Service of Nebraska, Omaha, Nebr | SP | 1.00 | 1.50 | 2.00 |
| New Hampshire-Vermont Hospitalization, Concord, N. H | SP | .85 | 1.70 | 2.00 |
| Hospital Service Plan of New Jersey, Newark, N. J | SP | .75 | ---------- | 2.00 |
| Hospital Service, Inc., Albuquerque, N. Mex | SP | .75 | 1.50 | 2.00 |
| Associated Hospital Service of Capital District, Albany, N. Y. | SP | .90 | 1.50 | 2.00 |
| Hospital Service Corp. of Western New York, Buffalo, N. Y. | SP | 1.00 | ---------- | 2.25 |
| | W | .80 | ---------- | 1.90 |
| Chautauqua Region Hospital Service Corp., Jamestown, N. Y. | SP | .80 | 1.60 | 2.00 |
| Associated Hospital Service of New York, New York City, N. Y. | SP | 1.00 | 2.20 | 2.72 |
| Rochester Hospital Service Corp., Rochester, N. Y | SP | .80 | ---------- | 1.90 |
| Group Hospital Service, Inc., Syracuse, N. Y | SP | .80 | ---------- | 1.90 |
| Hospital Plan, Inc., Utica, N. Y | SP | .70 | 1.10 | 1.30 |
| | W | .58 | .93 | 1.10 |
| Hospital Service Corp. of Jefferson County, Watertown, N. Y. | SP | .80 | 1.60 | 2.00 |
| Hospital Saving Association of North Carolina, Chapel Hill. N. C. | RA-5 | 1.15 | 2.30 | 2 60 |
| | RA-4 | 1.00 | 2.00 | 2.25 |
| | W | .60 | 1.20 | 1.60 |
| Hospital Care Association, Inc., Durham, N. C | RA-7 | 1.19 | 2.52 | 3.29 |
| | RA-6 | 1.02 | 2.16 | 2.82 |
| | RA-5 | .85 | 1.80 | 2.35 |
| | RA-4 | .72 | 1.50 | 2.00 |
| North Dakota Hospital Service Association, Fargo, N. Dak | SP | .75 | 1.50 | 2.00 |
| Akron Hospital Service, Akron, Ohio | SP | .85 | 1.75 | 2.25 |
| | W | .70 | 1.45 | 1.85 |

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[1] Effective Aug. 1, 1947.

*Tabulation of rates charged by Blue Cross Plans, July 31, 1947*—Continued

| Plan | Accommodations | Rates | | |
|---|---|---|---|---|
| | | 1 person | 2 persons | 3 persons |
| Hospital Service, Inc., of Stark County, Canton, Ohio | SP | $1.10 | | $2.30 |
| | W | .80 | | 1.80 |
| Hospital Care Corp., Cincinnati, Ohio | SP | .95 | | 2.25 |
| | W | .70 | | 1.75 |
| Cleveland Hospital Service Association, Cleveland, Ohio | SP | .85 | $1.70 | 2.15 |
| | W | .65 | 1.30 | 1.65 |
| Central Hospital Service, Columbus, Ohio | SP | .90 | | 2.25 |
| | W | .75 | | 1.90 |
| Hospital Service, Inc., Lima, Ohio | SP | 1.00 | 2.00 | 2.25 |
| Portsmouth Hospital Service Association, Portsmouth, Ohio. | P | 1.10 | 2.20 | 2.75 |
| | W | .80 | 1.60 | 2.00 |
| Hospital Service Association of Toledo, Toledo, Ohio | SP | 1.25 | 2.50 | [2] 2.95 |
| | W | .95 | 1.90 | 2.40 |
| Associated Hospital Service, Inc., Youngstown, Ohio | RA-6.50 | 1.15 | | 2.30 |
| | RA-5 | .90 | | 1.80 |
| Group Hospital Service, Tulsa, Okla | SP | .85 | 1.50 | 1.75 |
| | W | .60 | 1.25 | 1.50 |
| Northwest Hospital Service Plan, Portland, Oreg | W | 1.50 | 3.00 | 4.00 |
| Hospital Service Plan of Lehigh Valley, Allentown, Pa | SP | .75 | 1.50 | 2.00 |
| Capital Hospital Service, Inc., Harrisburg, Pa | SP | .85 | 1.75 | 2.25 |
| Associated Hospital Service of Philadelphia, Philadelphia, Pa. | SP | 1.00 | 2.00 | 2.50 |
| | W | .60 | 1.00 | 1.25 |
| Hospital Service Association of Pittsburgh, Pittsburgh, Pa. | SP | 1.00 | 2.00 | [1] 2.50 |
| | W | .75 | 1.50 | 1.90 |
| Hospital Service Association of Northeastern Pennsylvania, Wilkes Barre, Pa. | SP | .85 | 1.70 | 2.25 |
| | W | .50 | 1.10 | 1.40 |
| Hospital Service Corp. of Rhode Island, Providence, R. I. | RA-6 | .75 | | 1.90 |
| South Carolina Hospital Service Plan, Greenville, S. C. | W | .85 | | 1.90 |
| Tennessee Hospital Service Association, Chattanooga, Tenn. | RA-6 | 1.00 | | 2.00 |
| Community Hospital Service, Kingsport, Tenn | W | .75 | 1.25 | 1.50 |
| Memphis Hospital Service Association, Memphis, Tenn | RA-6 | 1.00 | | 2.00 |
| Group Hospital Service, Dallas, Tex | RA-5 | .90 | | 2.10 |
| Intermountain Hospital Service, Salt Lake City, Utah | SP | 1.00 | | 2.00 |
| Piedmont Hospital Service Association, Lynchburg, Va | RA-5 | .85 | 1.55 | 2.00 |
| | RA-3.50 | [3] .40<br>[4] .60 | 1.20 | 1.40 |
| Virginia Peninsula Hospital Service Association, Newport News, Va. | RA-4.50 | 1.00 | 1.50 | 2.00 |
| Tidewater Hospital Service Association, Norfolk, Va | P | 1.00 | 1.83 | 3.42 |
| | W | .83 | 1.33 | 2.50 |
| Virginia Hospital Service Association, Richmond, Va | SP | .85 | 1.50 | 2.00 |
| Hospital Service Association of Roanoke, Roanoke, Va | SP | .85 | 1.50 | 2.00 |
| | W | .60 | 1.10 | 1.40 |
| Washington Hospital Service, Seattle, Wash | RA-7.50 | 1.25 | 2.60 | 3.60 |
| Hospital Service, Inc., Charleston, W. Va | RA-5 | 1.25 | 2.00 | 2.80 |
| Blue Cross Hospital Service, Inc., Huntington, W. Va | W | 1.00 | | 2.00 |
| West Virginia Hospital Service, Inc., Wheeling, W. Va | SP | 1.00 | | 2.25 |
| Associated Hospital Service, Inc., Milwaukee, Wis | SP | .90 | | 2.00 |
| Wyoming Hospital Service, Cheyenne, Wyo | SP | 1.00 | | 2.25 |
| P. R. Hospital Service Association, San Juan, P. R | SP | .75 | | 1.50 |
| Associated Hospitals Services of British Columbia, Vancouver, British Columbia. | W | 1.00 | | 2.00 |
| Manitoba Hospital Service Association, Winnipeg, Manitoba. | SP | .95 | | 1.85 |
| | W | .75 | | 1.25 |
| Maritime Hospital Service Association, Moncton, New Brunswick. | SP | 1.00 | | 2.00 |
| | W | .70 | | 1.40 |
| Plan for Hospital Care, Toronto, Ontario | SP | .75 | | 1.50 |
| | W | .50 | | 1.00 |
| Quebec Hospital Service Association, Montreal, Quebec | SP | .90 | | 2.25 |
| | W | .60 | | 1.50 |

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[1] Effective Aug. 1, 1947.
[2] Effective Sept. 1, 1947.
[3] Male.
[4] Female.

Senator SMITH. Thank you very much, Mr. Colman. Any other material that you care to file, we will be glad to put it at the disposal of the committee.

The next witness is Dr. R. L. Novy, president of the Michigan Blue Cross, but I understand Mr. Novy is not present today.

Mr. Jay C. Ketchum, executive vice president of the Michigan Medical Service, Detroit Mich. Is Mr. Ketchum here?

Mr. Ketchum, will you make a brief statement of your background, biography so to speak, and your qualifications?

(Mr. Colman submitted the following brief:)

### STATEMENT OF THE BLUE CROSS COMMISSION OF THE AMERICAN HOSPITAL ASSOCIATION, CHICAGO 10, ILLINOIS

Mr. Chairman, and committee members, for the record my name is J. Douglas Colman, director of Maryland Hospital Service, Inc., the Blue Cross Plan serving Maryland, and lecturer in Public Health Administration, Johns Hopkins University. I appear as the representative of the Blue Cross Commission of the American Hospital Association.

The Blue Cross Commission is the national coordinating agency for 88 Blue Cross Plans by which 27,000,000 Americans place hospital care in their family budget. These 88 Blue Cross Plans operate as independent corporate entities. They are members of the American Hospital Association, of which the Blue Cross Commission is a part. Their services to subscribers are guaranteed by 3,500 member hospitals of Plans in 46 States, the District of Columbia, Puerto Rico, and 7 Canadian provinces.

Blue Cross Plans are nonprofit, community service agencies through which the public, hospitals, and the medical profession unit to make hospital care readily available to all who are self-supporting as to the other necessities of life.

In 1944 and in 1946 representatives of Blue Cross Plans appeared before Senate committees to suggest that the most productive role of the Federal Government in the field of health and medical care would be to encourage and support existing, worth while, local efforts—to supplement them, when necessary, but not to supplant them. Therefore, we endorse Senate bill 545, and urge its passage.

This testimony will focus upon three major topics:

1. Definition and scope of Blue Cross Plans;
2. Specific accomplishments of Blue Cross Plans, and a discussion of certain recent developments which indicate their continued virility and increasing potentiality for public service; and
3. Comment upon certain provisions of the bill with which Blue Cross Plans are directly concerned.

No attempt is made to discuss certain important phases of the bill with which our concern is less immediate, such as those dealing with the organization structure of the proposed National Health Agency.

#### DEFINITION AND SCOPE OF BLUE CROSS PLANS

Each Blue Cross Plan is a nonprofit corporation governed by a board on which are represented the public, the participating hospitals, and the medical profession of the State or community in which the subscribers are enrolled. The members of the governing board of a Blue Cross Plan receive no remuneration for their service—just as trustees of a university, hospital, or church. Their only reward is the satisfaction which comes from a job worth doing and well done. The administrative functions of Blue Cross Plans are discharged by salaried employees working under policies determined by the governing board.

Subscribers join through their places of employment, or through some other defined segment of the population. Regular and equal payments are accepted from subscribers and used to provide hospital service for those requiring care. In 53 of these 88 Plans, hospital care is supplemented by coordinated medically sponsored plans for medical and surgical care. In most cases the Plans are administered by the same personnel. The cost of hospital-plan membership is approximately 75 cents a month per person, or $2 a month per family. Subscription charges for medical and surgical care of hospitalized illness are approximately the same. As one would expect, these charges vary throughout the country, depending upon the services provided and the general cost level in the particular area.

By agreement with some 3,500 voluntary hospitals, Blue Cross subscribers receive benefits expressed in terms of hosspital service rather than cash allowances. Typically, these benefits provide for care in semiprivate accommodations and include the hospital services necessary for diagnosis and treatment of hospital-bed patients. They are available to each member of the family, usually for 3 or 4 weeks of full coverage with extended periods of care available at rates lower than the hospital's usual charge for such service.

To earn the right to use the Blue Cross symbol, a Plan must comply with the standards established in the approval program administered by the trustees of the American Hospital Association. These include monprofit operation, free choice of hospital and physician, hospital guaranty of service benefits, representation on the governing board of public, hospital, and medical interests, and the establishment and maintenance of financial reserves adequate to protect the interests, both of subscribers and member hospitals. In addition, most Plans are supervised by some State agency, usually the State department of insurance, and in most States must comply with the statutory requirements provided for in legislation specifically applying to such plans.

### RAPID GROWTH

Table I records the phenomenal growth of Blue Cross enrollment during the past decade. Two Plans were in operation as early as 1933. In January 1937, there were only 534,000 subscribers. One years ago we reported 21,000,000. Today we report that on April 1, 1947, there were 27,000,000 Blue Cross subscribers, of whom 25,000,000 were residents of the United States.

In table II the Blue Cross enrollment in the various States is compared with the estimated civilian population as of July 1945. More than 20 percent of the United States population now participates in Blue Cross.

Here is the record of a social program which has enrolled more participants in less time than any voluntary movement in the history of the world. There is yet no indication that it is approaching a saturation point which, through the years, has been set at anywhere from 5,000,000 participants up. Rhode Island Blue Cross has enrolled approximately 70 percent of the State's population, and Massachusetts and Delaware now have more than 50 percent of the population enrolled. Seven other States with a total population of 34,000,000 persons have between 30 and 40 percent of their population enrolled. Most of this has happened in 10 years. Clearly the voluntary, prepayment approach to the economic problems of health service cannot be dismissed lightly as an interesting experiment.

No secret formula produces these heartening results. Public interest and confidence are the simple ingredients. If these were augmented by the encouragement and support contained in Senate bill 545, the results would be even more phenomenal.

### RECENT DEVELOPMENTS IN BLUE CROSS

The growth and aceptance of Blue Cross Plans have far exceeded the expectations of their enthusiastic supporters of 10 years ago. Even more rapid, however, has been the growth of the responsibilities which Blue Cross Plans are called upon to undertake as the public becomes aware of their potentialities. This Section will review some of the progress made towards specific Blue Cross objectives.

(*1*) *Blue Cross membership is available to the population of 46 States and the District of Columbia.*—The geographical coverage of Blue Cross Plans has spread across the Nation. Increasing attention is being given to the enrollment of those segments of the population not routinely accessible through the usual group channels, such as craft workers, farm bureaus, granges, homemakers' clubs, volunteer fire departments, and so forth. As trained personnel becomes available, more Plans are concentrating efforts upon community-wide enrollment under the sponsorship of local citizens' committees. Other Plans have undertaken enrollment programs directed toward individuals for whom no group enrollment is possible.

(*2*) *Fifty-three of the 88 Blue Cross Plans offer complete protection for catastrophic illness through coordination with Plans for medical or surgical protection.*—From other witnesses you will hear the activities of prepaid medical care plans described more fully. However, it suffices to say that the enrollment in these Plans gives promise of growing at an even more rapid rate than did Blue Cross Plans at the same stage in their development. There are now approximately 5,000,000 participants in the medical care plans coordinated with Blue Cross Plans.

(*3*) *Blue Cross Plans have initiated an effective program of Nation-wide service to subscribers.*—Virtually all Blue Cross Plans participate in a joint agreement whereby subscribers of one Plan may transfer to another Plan without loss of benefits accumulated by length of membership. Fortunately, this program was initiated before the war and continuity of membership was possible for many citizens whose residences changed as a result of their participation in the war effort.

Similarly, Plans have entered into a reciprocal agreement whereby the subscribers of most Plans who require hospital care away from home are eligible for the same benefits as Blue Cross subscribers in the area in which the hospital care is received.

Under the auspices of the Blue Cross Commission, a National Enrollment Office has been established whereby the particular problems of groups whose members live in widely scattered geographic areas can be met effectively by the individual Plans serving those areas.

(4) *A high proportion of participation in some geographic areas and in some enrolled groups is evidence that Blue Cross subscription charges are within the ability-to-pay of most of the population.*—Almost 70 percent of the population of Rhode Island now voluntarily participates in its Blue Cross Plan. It is not unusual for Blue Cross Plans to enroll 75 percent, or more, of the members both of employed groups and individual communities in which community-wide enrollment efforts have been undertaken. There is every reason to believe that an overwhelming majority of the population will participate voluntarily in prepayment health service plans as the awareness of their value grows. Many persons enroll in Blue Cross despite their eligibility for some form of hospital care at the expense of tax funds.

(5) *Employers exhibit a growing interest in Blue Cross and an increasing willingness to share a portion of the subscription charges.*—Particularly in the presentation of medical care plans concurrently with hospital care plans is this employer contribution helpful. In some instances it has been the stimulus necessary to secure 100 percent participation in both hospital and medical care plans by a group of employees. Most plans encourage this by offering added benefits for 100-percent participation.

(6) *Plans report increasing percentages of participation among their enrolled groups and decreased cancellation rates.*—"Ask the man who owns one" is always a good test of any product or service. It is significant, then, that the bulk of the enrollment increase in most Plans, month after month, comes from an increase in the percent of participation among groups already established. It is doubtful if Blue Cross Plans will have a more severe test than that imposed by the widespread disruption of continuous employment resulting from both military service and domestic war work. It is revealing that the few months following the close of the war did not seriously disrupt the growth pattern of Blue Cross Plans and that the enrollment increase during the first months of 1946 was higher than during any previous period in the life of Blue Cross Plans. Blue Cross subscribers are encouraged to maintain their memberships when they sever their connection with the group through which they enroll and real progress has been made towards the goal stated in the slogan, "Once a subscriber, always a subscriber."

(7) *Widespread cooperation of employers has been received in the maintenance of Blue Cross membership of employees during work stoppages.*—Blue Cross Plans routinely maintain protection and defer collection of subscription charges during work stoppages. Employers consistently have agreed to undertake the collection and transmission of Blue Cross subscription charges for the interim period from those returning to work, and, in some cases, have advanced subscription charges for striking employees.

(8) *Operating costs of Blue Cross Plans have been kept low despite rapid growth.*—The entire cost of operating Blue Cross Plans averaged 13 percent of income during the year 1946. Realizing that costs expressed as a percent of income are always high during periods of rapid growth this record becomes doubly important. During 1946 many Plans were put to considerable expense keeping track of the migrations of their subscribers at the close of the war. Thus far, administrative economies, and those resulting from increased volume, have largely offset the increases expected as a result of the increased cost of the goods and services Blue Cross Plans purchased in the discharge of their administrative duties.

### COMMENTS ON SENATE BILL 545

Senate bill 545 would bring into being many of the forces Blue Cross long has hoped would supplement and extend its efforts to bring more and better health service to all. We urge its passage because—

(1) *Its provisions permit the full use of the potentialities for public service found in voluntary plans.*—Health needs are not a fixed quantity. They are ever-expanding. It is doubtful if the resources of any single agency, even the Federal

Government, can keep pace with them. Full utilization of all resources is imperative to attain maximum public service. Hence we welcome the bill's challenge to State and local agencies and to voluntary plans to form an effective partnership with the Federal Government.

(2) *It provides the authority necessary to offer Blue Cross membership to Federal employees.*—An estimated 300,000 of the 2,000,000 Federal employees now participate in Blue Cross Plans. This low ratio of participation is due to the difficulties of handling subscription payments without the cooperation of the employer. This provision of the bill will make Blue Cross available to at least 3,500,000 additional Federal employees and dependents. This action will signify the interest of the Federal Government in the entension of voluntary plans to the fullest degree justified by the public interest. This action by the Nation's largest single employer will stimulate similar action by many State, municipal, and private employers not now enrolled. Time of Federal employees consumed by present cumbersome procedures will be saved.

(3) *The State-wide study of health needs provided for in the bill will reveal additional and more effective uses of existing resources.*—In few States is there any public or private agency with official warrant constantly to compare what health services are available with what is known to be valuable and to plan systematically to repair the deficiencies. In a field as complex as the health services, planning is a necessary prelude to effective action. Also, it frequently is the stimulus of latent interests and energies that might otherwise lie dormant without the prod of local participation.

(4) *Federal assistance is offered in a manner which does not destroy in persons or localities their sense of ultimate responsibility.*—More liberal provisions for those States and those segments of the population less able to provide for their own need is sound when offered in a way which does not offend dignity or stifle initiative. The provisions of the bill make this possible. There is a mutuality in the provision of health services. There must develop within the patient an understanding—a desire for the service—a sense of participation. The most elaborate hospital construction or the finest laboratory equipment will not alone assure effective service to patients. The most carefully calculated diabetic diet is of no use unless the patient takes it home and lives by it. He is more likely to do that if he has an interest and faith in its source. Medical care given to patients who have no faith in it, nor desire for it, is frequently wasted. Our resources for health preservation are too limited to waste.

(5) *Hospital construction will be made feasible in areas which could not now support a hospital, if built.*—Few States now provide for the full cost of hospital care even to recipients of public assistance who receive all other necessities of life from tax funds. As a result, limited resources of hospitals are not fully available for service to paying patients. By carrying a portion of this load, the bill will increase hospital resources available to the entire population. In some areas this added support will permit hospitals to operate where they cannot now exist. Blue Cross cannot provide service where there are no hospitals. Hence we have a direct interest in this possibility of the bill.

Comment on certain specific features of the bill may be useful to the committee in its deliberations.

It would be desirable if the funds made available to States as grants-in-aid could extend the type and amount of health services now available. It would be regrettable if funds available under the bill were matched by some form of State expenditure that is now generally accepted as a State responsibility, or for which some other Federal matching funds are now available. The committee may wish to specify in the bill some types of State and local expenditures which are not eligible for grants-in-aid under this bill.

The natural function of the Medical Care Council seems to be to bring to the Federal Government the understanding and experience of persons who otherwise would have no official concern with the problems of the National Medical Care Council. However, the language on page 24 of the bill does not provide that the Council consist of "persons not otherwise in the employ of the Federal Government." Such provision is included with respect to the Dental Health Council.

The language contained on pages 21, 26, and 34 of the bill, specifying that the Federal administrative agency shall not determine the methods by which States accomplish the purposes of the bill, is vital. The administrative flexibility permitted in achieving defined objectives is an essential feature of the bill. Without that flexibility one of the greatest promises of the measure is forfeit. Nation-wide uniformity of method must not be confused with universal availability of service. The language referred to above should be preserved in its entirety as Congress proceeds with its consideration of the measure. Without the specific authorization of Congress, the Federal purse should not be used to dictate local methods of administration.

We subscribe to the findings of the bill that there are inadequacies in the distribution of health services. We endorse its statement of intent to aid States in correcting those inadequacies. We remind that Blue Cross Plans exist solely to make hospital care more available to all people. We welcome the partnership offered by this bill to join in a united attack on a problem that is beyond the capacities of any single agency of society.

We take violent issue with those who feel that universal availability of service can only be attained with centralized financing and centralized control. We believe just the opposite is true. Centralized health services, or centralized anything else, tend to become self-limiting.

We know that the ever-expanding horizon of medical science and health service provides a challenge to the fullest joint effort of all agencies—Federal, State, local, and voluntary.

We urge the passage of Senate bill 545 as the most productive step which can be taken now by the Federal Government to stimulate sound progress toward our mutual objective of more and better health service to all the people.

TABLE I.—*Total Blue Cross enrollment, Jan. 1, 1937 to Apr. 1, 1947*

| *Year* | *Total participants* | *Year* | *Total participants* |
|---|---|---|---|
| Jan. 1, 1937 | 534, 745 | Jan 1, 1943 | 10, 458, 899 |
| Jan. 1, 1938 | 1, 364, 975 | Jan. 1, 1944 | 13, 005, 493 |
| Jan. 1, 1939 | 2, 874, 055 | Jan. 1, 1945 | 16, 511, 198 |
| Jan. 1, 1940 | 4, 431, 772 | Jan. 1, 1946 | 19, 989, 205 |
| Jan. 1, 1941 | 6, 049, 222 | Jan. 1, 1947 | 25,876, 424 |
| Jan. 1, 1942 | 8, 456, 265 | Apr. 1, 1947 | 26, 916, 342 |

TABLE II.—*Blue Cross enrollment on Apr. 1, 1947, estimated civilian population as of July 1945, percent of population enrolled on Apr. 1, 1947*

| State | Number of plans | Enrollment Apr. 1, 1947 | Estimated civilian population July 1945 | Percent of population enrolled Apr. 1, 1947 |
|---|---|---|---|---|
| Rhode Island | 1 | 478, 515 | 698, 903 | 68. 47 |
| Massachusetts | 1 | 2, 015, 713 | 4, 086, 197 | 49. 33 |
| Delaware | 1 | 136, 768 | 277, 455 | 49, 29 |
| Colorado | 1 | 414, 374 | 1, 060, 239 | 39. 08 |
| Connecticut | 1 | 675, 000 | 1, 768, 602 | 38. 17 |
| Ohio | 9 | 2, 580, 142 | 6, 823, 137 | 37. 81 |
| District of Columbia | 1 | 301, 000 | 836, 900 | 35. 97 |
| New York | 8 | 4, 298, 881 | 12, 343, 450 | 34. 83 |
| Minnesota | 1 | 793, 000 | 2, 484, 993 | 31. 91 |
| Pennsylvania | 5 | 2, 841, 203 | 9, 142, 797 | 31. 08 |
| New Hampshire-Vermont | 1 | 217, 582 | 756, 141 | 28. 78 |
| Missouri | 2 | 941, 591 | 3, 481, 949 | 27. 04 |
| Maine | 1 | 195, 000 | 772, 621 | 25. 24 |
| Illinois | 4 | 1, 845, 299 | 7, 548, 109 | 24. 45 |
| New Jersey | 1 | 990, 333 | 4, 104, 176 | 24. 13 |
| Maryland | 1 | 471, 500 | 2, 017, 971 | 23. 37 |
| Michigan | 1 | 1, 167, 871 | 5, 435, 092 | 21. 49 |
| Wisconsin | 1 | 579, 465 | 2, 934, 044 | 19. 75 |
| Iowa | 2 | 423, 823 | 2, 236, 203 | 18. 95 |
| Utah | 1 | 89, 152 | 591, 910 | 15. 06 |
| Kansas | 1 | 245, 631 | 1, 656, 588 | 14. 83 |
| North Carolina | 2 | 474, 589 | 3, 333, 999 | 14. 23 |
| Montana | 1 | 60, 732 | 452, 519 | 13. 42 |
| North Dakota | 1 | 55, 000 | 519, 709 | 10. 58 |
| Virginia | 5 | 286, 677 | 2, 810, 278 | 10. 20 |
| Oklahoma | 1 | 180, 808 | 1, 941, 499 | 9. 31 |
| Kentucky | 2 | 206, 667 | 2, 520, 537 | 8. 20 |
| Arizona | 1 | 44, 759 | 589, 221 | 7. 60 |
| Nebraska | 1 | 85, 711 | 1, 155, 744 | 7. 42 |
| California | 3 | 596, 250 | 8, 120, 105 | 7. 34 |
| Idaho | 1 | 32, 409 | 459, 938 | 7. 05 |
| Louisiana | 3 | 163, 124 | 2, 343, 406 | 6. 96 |
| Indiana | 1 | 232, 001 | 3, 387, 463 | 6. 85 |
| Alabama | 1 | 184, 703 | 2, 728, 120 | 6. 77 |

TABLE II.—*Blue Cross enrollment on Apr. 1, 1947, estimated civilian population as of July 1945, percent of population enrolled on Apr. 1, 1947*—Continued

| State | Number of plans | Enrollment Apr. 1, 1947 | Estimated civilian population July 1945 | Percent of population enrolled Apr. 1, 1947 |
|---|---|---|---|---|
| West Virginia | 2 | 99,238 | 1,716,944 | 5.78 |
| Tennessee | 2 | 160,161 | 2,832,480 | 5.65 |
| Oregon | 1 | 64,720 | 1,193,702 | 5.42 |
| Washington | 1 | 92,792 | 1,953,725 | 4.75 |
| Wyoming | 1 | 10,421 | 234,553 | 4.42 |
| Florida | 1 | 87,458 | 2,059,505 | 4.25 |
| Nevada [1] | ---------- | 5,150 | 135,689 | 3.80 |
| Texas | 1 | 235,000 | 6,338,309 | 3.71 |
| Georgia | 2 | 73,559 | 3,002.896 | 2.45 |
| New Mexico | 1 | 10,340 | 490,302 | 2.11 |
| South Dakota [2] | ---------- | 3,274 | 526,607 | .62 |
| Total United States served by Blue Cross [3] | 80 | 25,147,386 | 121,904,727 | 20.63 |
| States not served by Blue Cross: Arkansas, Mississippi | ---------- | 0 | 5,504,570 | 0 |
| Total United States | 80 | 25,147,386 | 127,409,297 | 19.74 |
| Puerto Rico | 1 | 33,912 | [4] 1,869,255 | 1.81 |
| Canada: | | | | |
| Manitoba | 1 | 247,328 | 729,744 | 33.89 |
| Nova Scotia, New Brunswick, Prince Edward Island | 1 | 252,559 | 1,130,410 | 22.34 |
| Ontario | 1 | 799,145 | 3,787,655 | 21.10 |
| British Columbia | 1 | 106,833 | 817,861 | 13.06 |
| Quebec | 1 | 329,179 | 3,331,882 | 9.88 |
| Total Canada served by Blue Cross | 5 | 1,735,044 | 9,797,552 | 17.71 |
| Canadian Provinces not served by Blue Cross: Alberta, Northwest Territories, Saskatchewan, and Yukon Territory | ---------- | 0 | 1,709,103 | 0 |
| Total Canada | 5 | 1,735,044 | 11,506,655 | 15.08 |
| Grand total | [5] 86 | 26,916,342 | 140,785,207 | 19.12 |

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[1] Enrollment through Plan with headquarters at Sacramento, Calif.

[2] Enrollment through Plan with headquarters at Sioux City, Iowa.

[3] No enrollment as of Apr. 1, 1947 for newly approved Plans with headquarters at Memphis, Tenn., and Greenville, S. C.

[4] 1941 census.

[5] Enrollment figures shown for 86 Plans. To date there are 88 approved Blue Cross Plans. (See note 3)

TABLE III.—*Enrollment in medical and surgical plans as of Apr. 1, 1947*

| State | Number of plans | Enrollment Apr. 1, 1947 | State | Number of plans | Enrollment Apr. 1, 1947 |
|---|---|---|---|---|---|
| Michigan | 1 | 852,492 | Oklahoma | 1 | 27,877 |
| New York | 6 | 711,013 | Nebraska | 1 | 26,334 |
| California | 3 | 620,367 | Kansas | 1 | 22,331 |
| Massachusetts | 1 | 574,232 | Iowa | 2 | 18,951 |
| North Carolina | 2 | 345,872 | Montana | 1 | 18,282 |
| Missouri | 2 | 302,063 | Washington | 1 | 17,013 |
| Colorado | 1 | 203,637 | Utah | 1 | 12,229 |
| Ohio | 4 | 139,897 | Florida | 1 | 11,655 |
| Virginia | 5 | 117,720 | Oregon | 1 | 7,925 |
| Delaware | 1 | 109,562 | North Dakota | 1 | 6,523 |
| New Hampshire | 1 | 108,147 | New Mexico | 1 | 4,456 |
| New Jersey | 1 | 101,078 | | | |
| Indiana | 1 | 88,000 | Total, United States | 49 | 4,562,151 |
| Wisconsin | 1 | 70,300 | Canadian Plans | 3 | 163,926 |
| Alabama | 1 | 54,993 | Puerto Rico | 1 | 33,912 |
| Texas | 1 | 43,700 | | | |
| West Virginia | 2 | 36,002 | Grand total | 53 | 4,779,989 |
| Louisiana | 3 | 29,500 | | | |

## STATEMENT OF JAY C. KETCHUM, EXECUTIVE VICE PRESIDENT, MICHIGAN MEDICAL SERVICE, DETROIT, MICH.

Mr. **Ketchum.** Mr. Chairman, my background has been mainly in the insurance phases of the operation of voluntary, nonprofit health service. I have been executive vice president of the Michigan Medical Service in Detroit, Mich., for some 6 years. Prior to that I was engaged in the insurance business as company executive and as the deputy insurance commissioner of the State of Michigan for approximately 18 years, and I approach this testimony from the point of view of an insurance administrator and administrator of a nonprofit voluntary home care fund.

I must apologize for the appearance of the brief which I am filing, and I am sure you will find there are many errors of punctuation, and some typographical errors, due to the fact that I was not aware until Monday that I was to appear here and file a brief.

Senator **Smith.** Mr. Ketchum, do you want to make your own corrections in this brief?

Mr. **Ketchum.** There are no important errors. I don't believe there will be any difficulty in following the sense of it. Although I did not hear Mr. Colman's testimony, I believe he probably gave you facts and figures as to the amount of coverage extended by Blue Cross Plans, both hospital and medical plans throughout the United States, and knowing that Mr. Colman was to appear, and assuming he would cover those figures, I have not attempted to do that.

Suffice it to say that the growth has been rapid and the organization of plans in areas in which plans have been organized has come on rapidly, so that by and large throughout the United States people can obtain coverage under the Blue Cross Plan, those who are able to pay for the ordinary expenses of living.

On the question of the medical, indigent, and welfare load approached by the Taft bill, S. 545, it is a logical approach from our point of view. Recently in Michigan and in several other States throughout the United States techniques have been developed to handle the servicing of wards of the Government, individuals for whom the Government is responsible for providing medical care on other than an insurance basis.

Referring to the home volunteer plans for veterans, we started this plan in Michigan—I believe it was the first such plan in the United States—about 18 months ago. We have provided an increasing volume of care for veterans with complete physical research in their home towns. The volume has reached alarming proportions, as a matter of fact, in Michigan compared to what the estimates were at the time we entered into the agreement with the Veterans' Administration. It was estimated at the time that we would handle some $50,000 worth of care a month. Actually it is closer to $150,000 a month at the present time.

I am pointing this out to show that these voluntary medical care plans of the Blue Cross in the United States could provide that type of care under their program for these medically indigent and welfare loads which the bill provides for in—I think it is on page 18, paragraph 712 (a), 721 (7) (8), and so forth, title VII.

Senator SMITH. You mean by that, Mr. Ketchum, that from your experience in taking care of these veterans' cases, a program can be worked out which might be relied upon as an over-all health coverage?

Mr. KETCHUM. That is right. Welfare loads as we experienced the problem in Michigan are possible of insurance or coverage under these plans on an insurance basis. It depends on how many people are on the welfare rolls from month to month, and who they are, and it is possible to promulgate a rate or a premium which will cover those people for prepaid medical care or hospital care. The medically indigent, however, is another problem. These people are not known, and the number of them is not known until they need medical or hospital care. Then they become wards of the local unit of government, and they must provide care and the local unit pay for it.

Senator SMITH. You mean by the term "medically indigent," as I understand it, persons who have income sufficient to take care of ordinary expenses but not the extra amount needed for medical care? They can take care of themselves until an emergency arises; then they become welfare cases?

Mr. KETCHUM. Only at that time, and only when the emergency arises. It is impossible to treat with those people on an insurance basis, because you don't know what your problem is until you have it on your hands. However, this plan which has been worked out by the Veterans' Administration does provide a means for local units of government to take care of such people on a cost-plus basis. In other words, we agree to furnish the services of a physician or hospital, as the case may be, and bill the unit of government, and add to that cost of service only our overhead to handle it.

In this brief I have attempted to outline in the exhibits the amount of care which we have provided in Michigan under the Veterans' Administration program, the amount of overhead, and so forth, except for some of the problems in connection with it. You have the brief before you, and I could probably help by not taking up the time reading facts set forth in the brief.

I would like to point out that the main difficulty we have had with the Veterans' Administration program is not one of our own making, but the usual difficulty we have in dealing with many of the Government bureaus, that the Veterans' Administration itself has difficulty in living up to its part of the agreement, in that they have not the personnel, trained personnel, to check up payments and so on, to the extent that we have had to advance our own funds to the amount of $341,000 as of March 31 of this year, in order to provide this program. That, however, is being corrected gradually and is getting a little bit better than it was.

Senator SMITH. You mean you have had to take $341,000 out of your own Blue Cross funds to take care of the Veterans' Administration load?

Mr. KETCHUM. We have advanced that much, yes, sir; that has not yet been collected from the Veterans' Administration.

Senator DONNELL. How long has that money been owing to you?

Mr. KETCHUM. About 2 months' operation under the program.

Another section of this bill which I think is tremendously important to the public, and particularly to the voluntary health care program, is section 306, which provides that Federal departments, bureaus, agencies, and so forth, shall, upon request, provide for pay-roll deductions for membership of its employees in voluntary health insurance programs. One of the most inconsistent positions that the Government has taken is the refusal to permit such pay-roll deductions for its employees in such plans as this inasmuch as the Government uses the method probably more than any other organization, for instance, in pay-roll deductions for income-tax purposes, the sale of bonds, social security, and so on. That provision alone, if it were enacted, regardless of whether the rest of the bill were enacted at this session or not, I believe should have serious consideration, even as a separate measure.

Senator SMITH. You would make that voluntary? You would not make it compulsory?

Mr. KETCHUM. No; voluntary. On request, compulsory upon the department or the administrator of the department or agency, but at the request of the employee.

Senator SMITH. I meant voluntary so far as the individual is concerned.

Mr. KETCHUM. Yes, sir.

Senator SMITH. Do you have some points you wanted to emphasize particularly with regard to the brief here, that you have not already referred to?

Mr. KETCHUM. I believe not. I think that the brief covers the points which I intended to cover, as well as can be done in a short period of time.

Senator SMITH. Do you want to make any comment, Mr. Ketchum, on the relative approaches of a compulsory insurance plan and the plan as contemplated in the so-called Taft bill, S. 545?

Mr. KETCHUM. I did not hear all of Mr. Colman's testimony, so probably I am likely to repeat much of what he said in regard to that question.

Very definitely I feel that the approach of the Wagner-Murray-Dingell bill of last year—I have not seen this year's bill at all—is not an insurance plan at all in the true sense of the word. It is a compulsory system of taxation. I dislike very much the use of the word "insurance" in connection with such a program.

Senator DONNELL. You are speaking now about S. 1320?

Mr. KETCHUM. Yes; this year, as I understand it.

Senator DONNELL. Would you discuss that a little?

Mr. KETCHUM. I have not seen this bill but I have seen the previous bill. It is not insurance in any sense of the word. It is compulsory taxation for the purposes outlined in the bill. Further than that, the previous bill has not guaranteed the public anything in the way of medical care. The implications, I believe, that Senator Pepper meant to convey in connection with Mr. Colman's testimony as to the various types of care were that the bill did provide certain specific types of medical hospital care. Iwould like to argue that point out, that the bill does not, with one or two exceptions, guarantee anything. Under the administration there are ways and means of voicing the various provisions and benefits in connection with medical care that the administration may use if they find it necessary. For instance, the addition or the requirement that the patient pay a fee over and above a certain set amount per call, or that he provide payment for all of his laboratory care or laboratory work, and things of that kind. In other words, there are "outs" in the insurance business—we call it the fine type that is hidden down at the bottom of the page in the insurance contract. So that under this public hospital bill if it were enacted there is no assurance of what they would get for their deductions or their contributions or what they pay in.

Senator SMITH. You mean by that, as I understand your statement, that if they have pay-roll deductions to go into the fund to provide over-all medical care and hospital care, the time will come when the Government cannot deliver, and the man who has paid for coverage will not get it?

Mr. KETCHUM. That is it.

Senator SMITH. That was suggested by one of the witnesses yesterday, that it would not be possible for the Government to deliver the goods after having collected this vast sum of money by taxing people, and that it would be a great disappointment to the people because they would not get what they thought they had paid for. Now, your suggestion is that the bill does not even make those commitments, that it has "outs" so far as the Government is concerned, in case they cannot deliver for the amount of money collected?

Mr. KETCHUM. That is true as to almost every phase of the 69 phases of the type of service which is mentioned in the bill.

Senator SMITH. And you say there is no relation in analogy between a pay roll tax based on what a man earns, and a premium based on the cost of the service?

Mr. KETCHUM. That is one other reason why I feel that the word "insurance" is a misnomer in connection with that bill. The amount paid into the fund bears no relationship to the benefits which the individual may take out. If they spread the tax in accordance with the ability to pay, such as an income tax, it has no relationship to a premium for insurance. The amounts to be deducted, although they were not set forth in the last bill, as I understand it, would be left to separate action of the Congress later. In the previous bills, however, they bore no actual relationship to the risk or hazard involved. There was no actuarial computation or promulgation of rates whatever.

Senator SMITH. Senator Pepper, our time is drawing to a close, and I will give you an opportunity to interrogate the witness at this time if you care to.

Senator PEPPER. Thank you very much, Mr. Chairman.

Mr. Ketchum, I call your attention to a letter that has been addressed to this committee, dated May 21, 1947, signed "George F. Addes, Secretary-Treasurer, International Union, UAW-CIO" in which he says:

> I am advised that the subcommittee of the Senate Labor and Welfare Committee is now conducting hearings on Senate bill 545. On behalf of the members of the UAW-CIO, I would like to present our views in opposition to the provisions of this bill.
>
> Our union has repeatedly endorsed the approach toward national health insurance problems as developed in the Wagner-Murray-Dingell bill which was introduced during the last session of Congress and which, I am informed, will be reintroduced at the present session. While we would support any other measure designed to meet the health problems of our members and the American people in general, even though such measures did not adequately meet the whole problem, we cannot support S. 545. Our principal opposition to this proposal does not arise from the fact that it is insufficient to meet the need, but, because, in our opinion, its approach to the problem is fundamentally wrong.

S. 545, despite its designation as a national health bill, bears as little relationship to a national health program as did the poorhouse system to a social-security program.

The proposal rejects the typically American insurance principle under which a person could obtain benefits as a matter of right because he had made his proportional contribution. It substitutes the degrading "means" test under which a person most prove that he cannot afford to pay for medical services before he or his family can get medical attention.

The propagandists talk glibly of the Wagner-Murray-Dingell bill as undermining American institutions. I can conceive of no more effective means of undermining the morale—the independence—of the American people than by imposing this "means" test upon their right to obtain medical care.

It's hard enough to be poor without being required to prove it if your kids get sick.

The American Medical Association and certain other organized groups have asserted that the Wagner-Murray-Dingell bill, which would provide medical services through an insurance fund to which everyone would contribute, is communistic. S. 545 is now presented as a substitute. Presumably these same gentlemen support S. 545 in the belief that it is free from such contamination, and that it represents the highest manifestation of American principles. We are unwilling to assume that the American way of life requires our Government to stigmatize an American as a pauper before it can provide him and his family with necessary health protection.

We believe there is no alternative to a national health insurance plan, if health protection is to be made available to every American, rich or poor alike.

An effort has been made to create the impression that voluntary health plans which have had some measure of success in the past few years, particularly the Blue Cross Plans, are an adequate substitute for a national health program. Frequent reference is made to the Michigan Blue Cross Plans as an outstanding example. Our extensive experience with the operation of these Plans does not support the conclusion that now or in the future they will ever serve as a substitute for an adequate national health program.

In Michigan the Michigan Medical Service and the Michigan Hospital Service has been established to provide an insurance plan with the avowed purpose of taking care of the health needs of the people. For 6 years the UAW-CIO has supported these services. Today our members constitute approximately 50 percent of their subscribers. It has largely been due to the support of our union in Michigan that these plans have achieved their present enrollment.

However, our original decision to support these Plans was not made because we believed they provided any real solution for the health problems of our members. Six years' experience with these Plans has not changed our opinion. On the contrary, it has reinforced it.

The hospital Service Plan has been the more successful of the two Blue Cross Plans. This limited success was due to the fact that in the majority of cases total costs have been paid by the Service and only in a relatively limited number of cases has the worker been required to pay an additional amount. However, even with respect to the hospital service, there are three principal weaknesses.

1. Only approximately one out of every five persons in Michigan is covered by the Plan. A large proportion of the persons not covered are those who are most in need of the protection.

2. A large number of hospitals, representing approximately 20 percent of all the hospital beds, do not participate in the Plan. A chain of 14 hospitals withdrew from the Plan during the past year. Any member who is brought into a nonparticipating hospital must pay almost once again as much for his care as the hospital receives from the Plan.

3. The cost is high—this may account for the fact that a majority of the people have not subscribed to the Plan. At present it costs a worker approximately $35 per year for his family for hospitalization.

The heart of any real health insurance program is the medical protection it provides. Hospitalization is frequently only the end result of lack of early and proper medical care. The Michigan Medical Service has proved completely inadequate to provide for the medical needs of our members. While we have supported the Plan because we have felt that it is the best available Plan, it has demonstrated to us that voluntary plans are definitely not the answer to the health needs of the American people. The Plan has a number of fundamental weaknesses:

1. It provides for no medical care, except that a special Plan at extra cost, providing for limited medical care while confined in a hospital, has been sold to a few subscribers. Surgical care at the home is not provided. Surgical care in the doctor's office is limited to emergency accident cases up to $15 per year.

2. It provides only limited protection for the restricted surgical services. The plan pays the doctor on the basis of an established fee schedule. If the subscriber's own doctor is not a participating member of the plan, he is not bound to accept the fee schedule of the Michigan Medical Service and he may charge any fee which he feels is reasonable and apply the amount received from the service on his bill.

Where the subscriber's doctor does participate in the Plan, he may nevertheless charge the subscriber more than the schedule rate if the combined income of the subscriber and his family is more than $2,500 per year.

This income limitation provision has completely destroyed the original objective of the Plan. For the past 5 years most of our members have averaged more than $2,500 income per year. They have discovered that in a very large proportion of the cases they are billed over and above the amount which the doctor receives from the Michigan Medical Service. So the worker finds that his premium has only partly paid for the limited surgical service which the plan provides.

As an illustration of this development, in 1941 the average cost to a Detroit worker for an appendectomy was $75. The Michigan Medical Service provides a $75 fee which usually took care of the doctor's entire bill. After 1942, the average cost to the Detroit worker for an appendectomy had risen to $150. Only a few months ago the Plan increased its fee for an appendectomy to $100. But despite this increase, the worker finds that after paying his premium to the Michigan Medical Service he still has a $50 bill to pay the doctor.

3. No real effort has been made to safeguard the interest of the subscriber so far as it concerns the amount of the fee charged by the doctor. The Plan is controlled by the doctors and there has been little inclination on their part to remedy the complaints of subscribers.

The grave limitations of the Blue Cross Plans are best illustrated by showing the extent to which people have turned to private insurance companies in a hopeful but futile effort to obtain health protection for their families.

I have had prepared, and am submitting to this committee, a table based on information published by the Michigan Department of Insurance, showing premium received and the benefits paid by the four leading private health and hospital insurance companies which have sold policies in Michigan during 1941–44. I have included similar figures for the Blue Cross Plans. I urge the committee to study this table.

I believe that an analysis of these figures justifies the following observations:

1. Although the Blue Cross Plans increased their business from over $3,000,000 in 1941 to over $12,000,000 in 1944, or an increase of approximately $9,000,000, the private insurance companies during the same 4-year period increased their business from over $23,000,000 to over $42,000,000, or an increase of $19,000,000. Thus it would appear that the increasing concern of people for an insurance plan which might give them real health protection resulted in private insurance companies obtaining twice as much of the new insurance business in Michigan as the Blue Cross Plans.

2. The private companies pay back to the subscriber an amount which varies from 19 percent to 57 percent for each premium dollar paid in. The average amount which the subscriber recovers from these companies is only 43 cents on his premium dollar. Most of the difference, totaling approximately $75,000,000 in 4 years, obviously represents excessive operating costs, high salaries, high pressure promotions, and huge profits.

3. One private insurance company alone did a business of over $124,000,000 during this 4-year period, almost four times greater than the combined Blue Cross Plans. In its extensive advertising and promotional campaigns this company promises the subscriber complete hospital, medical, and surgical care. It plays upon the deep desire of people for the complete protection which the Blue Cross Plans do not offer. And by holding out this alluring promise to the subscriber and his family, this one company collected in Michigan alone over $124,000,000 in this 4-year period, and paid out in benefits only $52,000,000.

The table demonstrates that one of the most important results from the increased public interest in medical and hospital insurance plans during the past few years, since the Wagner-Murray-Dingell bill was first introduced in Congress, has been the tremendous increase in the business of private insurance companies, who have thereby reaped phenomenal profits. One can hardly blame them for opposing the enactment of the Wagner-Murray-Dingell bill, since such a development would simply put them out of the health and hospitalization business at their present rates.

The concern of our members for an adequate national health program is real and immediate. It arises out of their daily needs. They have found that they are unable to bridge the gap between their income and the medical needs of their families. They are not theorists or idealists. They seek a practical solution to their problem. They believe that a comprehensive national insurance program of the kind proposed in the Wagner-Murray-Dingell bill is the only practical solution. It has been demonstrated that, by the application to the whole Nation of the principle of prepaid insurance, the cost of such a program will be very little more than the present cost of inadequate medical care to the American people.

We therefore urge the rejection of S. 545 and the adoption of a comprehensive national health program as outlined in the Wagner-Murray-Dingell bill.

Very truly yours,

George F. Addes,
*Secretary-Treasurer, International Union. UAW-CIO.*

*Table of premiums collected and benefits paid by leading sick and hospital benefit insurance companies doing business in Michigan, 1941–44, based on 1942–45 annual reports issued by Michigan Insurance Department*

| | 1941 | | | 1942 | | |
|---|---|---|---|---|---|---|
| | Premiums received | Benefits paid | Percent benefits paid to premiums received | Premiums received | Benefits paid | Percent benefits paid to premiums received |
| ASSESSMENT OR COOPERATIVE COMPANIES | | | | | | |
| Associated Mutual Hospital Service of Michigan, Detroit | $113,511.97 | $55,914.86 | 49 | $138,006.21 | $63,922.05 | 46 |
| Michigan Hospital Benefit Association, Detroit | 696,498.56 | 480,083.12 | 69 | 896,168.48 | 556,785.19 | 62 |
| Mutual Benefit Health and Accident Association, Omaha | 22,254,221.49 | 10,144,251.68 | 46 | 27,007,698.55 | 11,158,736.62 | 41 |
| Northern Mutual Casualty, Chicago | (1) | (1) | ---------- | 566,835.00 | 65,044.00 | 11 |
| Total | ---------- | ---------- | ---------- | ---------- | ---------- | ---------- |
| NONPROFIT ASSOCIATIONS | | | | | | |
| Michigan Hospital Service, Detroit | 2,795,242.30 | 2,061,335.27 | 74 | 4,881,539.73 | 4,100,374.84 | 84 |
| Michigan Medical Service, Detroit | 974,604.06 | 789,254.88 | 81 | 2,600,281.58 | 2,208,623.42 | 85 |
| Total | ---------- | ---------- | ---------- | ---------- | ---------- | ---------- |

| | 1943 | | | 1944 | | |
|---|---|---|---|---|---|---|
| | Premiums received | Benefits paid | Percent benefits paid to premiums received | Premiums received | Benefits paid | Percent benefits paid to premiums received |
| ASSESSMENT OR COOPERATIVE COMPANIES | | | | | | |
| Associated Mutual Hospital Service of Michigan, Detroit | $162,367.11 | $72,749.24 | 45 | $203,045.15 | $90,012.94 | 44 |
| Michigan Hospital Benefit Association, Detroit | 1,093,543.77 | 565,929.86 | 52 | 1,533,551.00 | 821,784.00 | 53 |

[1] No report.

*Table of premiums collected and benefits paid by leading sick and hospital benefit insurance companies doing business in Michigan, 1941–44, based on 1942–45 annual reports issued by Michigan Insurance Department*—Continued

| | 1943 | | | 1944 | | |
|---|---|---|---|---|---|---|
| | Premiums received | Benefits paid | Percent benefits paid to premiums received | Premiums received | Benefits paid | Percent benefits paid to premiums received |
| ASSESSMENT OR COOPERATIVE COMPANIES—con. | | | | | | |
| Mutual Benefit Health and Accident Association, Omaha | $33,395,350.11 | $13,191,150.51 | 39 | $41,743,810.56 | $17,771,793.68 | 43 |
| Northern Mutual Casualty, Chicago | 788, 122. 00 | 142, 593. 00 | 18 | 905, 407. 00 | 215, 813. 00 | 24 |
| Total | | | | | | |
| NONPROFIT ASSOCIATIONS | | | | | | |
| Michigan Hospital Service, Detroit | 6, 399, 890. 38 | 4, 863, 958. 18 | 76 | 7, 739, 198. 36 | 6, 085, 796. 84 | 79 |
| Michigan Medical Service, Detroit | 3, 488, 464. 41 | 2, 876, 547. 90 | 83 | 4, 624, 417. 88 | 3, 437, 265. 50 | 74 |
| Total | | | | | | |

| | Total, 1941–44, premiums received | Total, 1941–44, benefits paid | Percent benefits paid to premiums received 1941–44 |
|---|---|---|---|
| ASSESSMENT OR COOPERATIVE COMPANIES | | | |
| Associated Mutual Hospital Service of Michigan, Detroit | $616, 930. 44 | $282, 599. 09 | 46 |
| Michigan Hospital Benefit Association, Detroit | 4, 219, 761. 81 | 2, 424, 582. 17 | 57 |
| Mutual Benefit Health and Accident Association, Omaha | 124, 401. 080. 71 | 52, 265, 932. 49 | 42 |
| Northern Mutual Casualty, Chicago | 2, 260, 364. 00 | 423, 450. 00 | 19 |
| Total | 131, 498, 136. 96 | 55, 396, 563. 75 | 42 |
| NONPROFIT ASSOCIATIONS | | | |
| Michigan Hospital Service, Detroit | 21, 815, 870. 77 | 17, 111, 465. 13 | 78 |
| Michigan Medical Service, Detroit | 11, 679, 767. 93 | 9, 311, 691. 70 | 80 |
| Total | 33, 495, 638. 70 | 26, 423, 156. 83 | 79 |

Senator SMITH. Might I ask, Senator Pepper, if that document was sent to the committee or to the Senator himself?

Senator PEPPER. It was sent to the committee, but a copy of it was sent to me.

Senator DONNELL. What is the date of that?

Senator PEPPER. The date it was supposed to be sent to the committee is May 23, 1947.

Senator DONNELL. I wonder if a copy was sent to each member of the committee?

Senator PEPPER. I don't know whether it was or not, Senator. I only have this particular copy.

Senator SMITH. I have not been advised of the receipt of this letter.

Senator PEPPER. I was merely calling attention to it, in order to have it set forth fully in the record.

Senator Smith. That will be done.

Mr. Ketchum. May I ask if that date is May 23, 1946?

Senator Pepper. May I suggest, Mr. Chairman, that after Mr. Ketchum concludes, if he would like to file anything in response, of course he may be permitted to do so.

Senator Smith. I would like very much to have Mr. Ketchum do that.

Mr. Ketchum. May I ask, is this letter dated 1946 or 1947?

Senator Pepper. It is dated May 21, 1947.

Mr. Ketchum. It is almost an exact copy of a letter and testimony at the hearing on the Wagner bill last year. Mr. Addes has taken that position before. There is nothing new in that, and that is, I will admit, the official attitude of the UAW-CIO, that Michigan Hospital Service, also Michigan Medical Service, are utilized by them as the best thing available, but they prefer to enactment of the compulsory health insurance bill. I would like to answer a couple of the statements made in that letter, however, for the record.

Mr. Addes seems to assume that a compulsory health insurance bill would include in its operation as participating hospitals and doctors and hospitals, which would not be true. It is provided in the old bill—not speaking of the new one—that any hospital or doctor may participate or may not participate, if he does not choose to. Therefore it is quite likely that there would be hospitals and there would be doctors who would not be available under that compulsory bill, under the provisions of the bill. So it is quite likely it would have the same weakness that we have, in that we do not have all hospitals available. There are 140 some hospitals at the present time out of about 152 available hospitals, general hospitals, participating in Michigan Hospital Service, and about 76 percent of the doctors participate in the Michigan Medical Service program.

I might also point out that although we do have an upper income limit for full service without extra charge of $2,500 for a family and $2,000 for a single person, many of these people are so hard up that they cannot pay the casual home- and office-call fee, or something over and above our standard schedule of fees to doctors. If their incomes are insufficient how is it that they can afford to pay income tax at the rate of $50 per family for a married man with two children, if he earns $2,500, or $254, if he is a single man earning $2,000? If they are so hard up that they cannot pay a casual home and office fee, certainly the Government should not be taxing them at this rate.

Senator Pepper. You mean 3 percent withholding?

Mr. Ketchum. I am talking about income tax. I am pointing out that these people are not so hard up but what they can pay out of pocket ordinary, casual home and office bills and such as that.

Senator Pepper. Mr. Chairman, I would also like to place in the record a statement appearing in the Catholic Gazette, Kalamazoo, Mich., dated March 19, 1947, A Report to Our Subscribers. The Blue Cross Plans. Michigan Hospital Service—Michigan Medical Service.

Is that a correct statement?

Mr. Ketchum. Yes.

Senator Pepper. I would like to have that inserted in the record, Mr. Chairman.

Senator Smith. It will be done.

(The clipping from the Gazette, Kalamazoo, Mich., follows:)

### The Blue Cross Plans (Michigan Hospital Service—Michigan Medical Service) Statement of Condition

This statement is published in the interest of the more than 1,160,000 members of the Blue Cross Plans in Michigan and of the 5,000 cooperating employers which make this service available to them.

Something of the Blue Cross record of nonprofit public service to the people of Michigan is reflected in these reports. Four thousand two hundred Michigan doctors who share in the operation of Michigan Medical Service as developed by the Michigan State Medical Society, and 128 Michigan hospitals, which operate Michigan Hospital Service, are proud to present these financial reports to the people of Michigan whom they serve.

Since 1939 Blue Cross has paid $56,530,644.86 for hospital-surgical-medical care rendered Michigan subscribers.

*Report of condition as of the close of business December 31, 1946—résumé of statements filed with Michigan Insurance Department*

#### MICHIGAN HOSPITAL SERVICE

| | |
|---|---|
| ***Assets*** | |
| Cash in banks and office | $2,265,905.90 |
| United States Treasury and defense bonds | 1,756,300.00 |
| Accrued interest | 7,614.30 |
| Subscription fees—receivable | 132,937.81 |
| Other assets | 15,280.94 |
| Total assets | 4,178,038.95 |
| ***Liabilities and reserves*** | |
| Reserves for payment for services rendered subcribers (including unreported) | $2,030,625.72 |
| Reserve for unearned subscription fees | 732,157.69 |
| Reserve for contingencies | 1,298,063.23 |
| Other liabilities | 117,192.31 |
| Total liabilities and reserves | 4,178,038.95 |
| Total benefits paid since inception | 37,784,657.16 |

#### MICHIGAN MEDICAL SERVICE

| | |
|---|---|
| ***Assets*** | |
| Cash in banks and office | $845,527.18 |
| United States and Canadian Government bonds | 1,095,526.72 |
| Accrued interest | 7,729.14 |
| Subscription fees—receivable | 50,827.44 |
| Funds advanced for Veterans' Administration | 294,163.36 |
| Other assets | 6,657.13 |
| Total assets | 2,300,430.97 |
| ***Liabilities and reserves*** | |
| Reserves for payments for services rendered subscribers (including unreported | $753,421.49 |
| Reserve for unearned subscription fees | 279,050.36 |
| Reserve for contingencies | 1,251,330.82 |
| Other liabilities | 16,628.30 |
| Total liabilities and reserves | 2,300,430.97 |
| Total benefits paid since inception | 18,745,987.70 |

The Blue Cross Plan

MICHIGAN HOSPITAL SERVICE—MICHIGAN MEDICAL SERVICE

234 State Street, Detroit 26, Michigan

Senator Pepper. Mr. Chairman, before we conclude—I do not want to interrupt the Senator from Missouri—but before we conclude I want to ask that there be incorporated in the record following the testimony of Mr. Ketchum a statement appearing in the Boston Daily Globe of Wednesday, May 21, 1947, headed "Eighty-four percent in State can't pay cost in sick siege, says doctor," being the news report of an address made to the Massachusetts Medical Society in the week of May 21 of this year, entitled "Dr. Leland S. McKittrick, Boston Surgeon," in which he has this paragraph on compulsory insurance, Government-sponsored:

> Compulsory insurance and examination of hospital costs to find means of cutting them were his solution.

Then he goes on to say:

> Compulsory insurance, Government-sponsored, is unnecessarily costly.

I would like this whole statement to be included in the record.

I would like also to have—this is all current comment—a series of newspaper comments on the Blue Cross Plan appearing in reputable papers, such as the Star-Ledger, Newark, N. J., last year, December 24, 1946: "Three dollar fee ends as medical costs soar."

Another one from the Telegram, Worcester, Mass., April 26, 1947: Hospitals Hit Blue Cross Pay.

Another one from the Newark News, December 6, 1946: Hospital Plan Ups Payments.

Journal of Commerce, New York City, January 7, 1947: Maine Blue Cross Announces Changes in Plans.

Portland Oregonian, January 17, 1947: Blue Cross Hikes Costs, Benefits.

Democrat and Chronicle, Rochester, N. Y., March 15, 1947: Hospital Insurance Due To Rise.

Philadelphia, Pa., News, March 31, 1947: Blue Cross Increase Spells Extra Service.

Post-Gazette, Pittsburgh, Pa., December 17, 1946: Hospital Care Official Asks Cooperation.

The News, Buffalo, N. Y., February 8, 1947: Blue Cross Reports $712,018 Surplus: Serves 40 percent of WNY.

Another one from PM, New York City, August 2, 1946: Hospital Plan May Boost Rates.

Another one from the Chicago Journal of Commerce dated August 23, 1946: Blue Cross Plan Saves Life in Ontario.

And one more, the Republican, Waterbury, Conn., August 17, 1946—which I take it is the land of my colleague—entitled—this is only a news dispatch, "CIO Hits New Blue Cross Rate Boost."

Senator SMITH. I am glad to hear my colleague quoting from a Republican paper. I imagine some of these papers carried these news items in a broad-minded way, with the intention to hear all sides.

Senator DONNELL. Characteristically Republican.

Senator SMITH. Characteristic of Republican policy.

Senator PEPPER. I have no further comment on Dr. Ketchum's statement.

Senator SMITH. You are asking to have these newspaper clippings placed in the record?

Senator PEPPER. Yes, sir.

Senator SMITH. It is so ordered.

(The newspaper clippings referred to follow:)

[The Boston Daily Globe, Wednesday, May 21, 1947]

### EIGHTY-FOUR PERCENT IN STATE CANNOT PAY COST IN SICK SIEGE, SAYS DOCTOR

Massachusetts doctors, meeting in the one hundred and sixtysixth annual meeting of the Massachusetts Medical Society this week, were concerned most of the opening day with the rising cost of adequate medical care for the whole population and with ways of meeting it.

Dr. Leland S. McKittrick, Boston surgeon, declared that Massachusetts incomes of less than $3,000 a year for 84 percent of the population are inadequate to meet the cost of serious illness. A $3,000 income, he pointed out, is less than $60 a week. Sixty-nine percent of Massachusetts people earn $2,000 or less a year, and this excludes the unemployed. Yet hospital care without special nursing or professional fees, in a ward or semiprivate room, costs today in Boston $80 to $90 a week, said the surgeon.

Compulsory insurance and examination of hospital costs to find means of cutting them were his solution. Compulsory insurance, Government sponsored, he said, is unnecessarily costly.

Other doctors found a large segment of the Bay State population covered by some kind of insurance.

### FOURTEEN PERCENT GET VETERANS' CARE

Winthrop Adams, branch medical director of the Veterans' Administration, said 600,000 veterans in Massachusetts, 14 percent of the population, are beneficiaries of laws entitling veterans to some kind of hospital and out-patient care. Of these, he said, 89,000 are veterans with service-connected disabilities.

While the Veterans' Administration has 4,797 beds in 5 hospitals in Massachusetts, it has estimated that more than 15,000 beds will be required for veteran care in New England by 1965.

The Blue Cross acts for 50 percent of hospital admissions here, Jarvis Hunt, general counsel for Associated Industries, said, summing up the afternoon symposium on medical care. The Blue Shield provides sugical and obstetrical care for 600,000 persons. Both these are voluntary insurance plans. In addition, workmen's compensation offers medical care for industrial accidents and cash benefits to nearly one-fourth the population at a cost last year to industry of $40,000,000.

### STATE SHOULD ADMINISTER

"Industry is not ready to accept a compulsory sickness-benefit plan," he said. "We believe that—

"1. Local or State government should assume responsibility of providing adequate medical care for those unable to obtain it. A great part should be furnished by Federal grants but administration should be at State level.

"2. Medical care for those who are able to purchase it by direct payment, voluntary prepayment plans, or pay-roll deductions, is the responsibility of the individual. It may be met through collective bargaining with employers, through voluntary agreements entered into between employer and employee."

Dr. Elmer S. Bagnall, of Groveland, former president of the society, said the only logical way to meet costs of serious illness for the "medically indigent" is by Government subsidy.

"Massachusetts still has the poorest teeth in the United States in spite of a relatively low-cost barrier," Dr. Bagnall said. "There is need for utilization of more dentists in the State. There should be more and better district health councils. But the general practitioner is still the backbone of the system of distribution of medical care to the people."

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[Star-Ledger, Newark, N. J., December 24, 1946]

## THREE-DOLLAR FEE ENDS AS MEDICAL COSTS SOAR

(Special to the Star-Ledger)

NEW YORK.—Medical authorities throughout the country expect the 2- or 3-dollar doctor's fee for an office or home visit to disappear from the contemporary scene, as medical costs—from hospital accommodations to glass eyes—continue to soar.

The Physician's Forum, a Nation-wide organization whose members belong to the American Medical Association, said today that an informal survey among its physicians revealed that all expect doctors' fees to rise, and have already noticed some increases. The Medical Society of Greater New York said that the average charge of its members today was $5 for an office visit, as against $4 a year ago. This amounts to a 20-percent rise.

Hospital costs, too, are moving upward. A spokesman for the United States Public Health Service said that in parts of the country the average cost of "a hospital bed day" had doubled over prewar figures. And it is costing the city of New York $43,000,000, to support a hospital system that last year cost between 35 and 36 million dollars.

### BLUE CROSS UPS RATES

The Blue Cross Hospital Plan has announced that its rates have been raised in 42 localities, and that since 1939 it has raised daily payments to member hospitals from $7.75 to 9.18 per day per patient. A recent survey by the United Hospital Fund—a nonprofit organization—shows that similar payments in their voluntary hospitals were up almost 25 percent since 1943.

But the fund says that its average cost for maintaining a patient in a hospital for 1 day is 30.6 percent more than it was in 1943.

Since medical fees on the doctor-patient basis are not regulated, it is difficult to determine just where they have risen most. But both Physician's Forum and the New York State Medical Society point out that many doctors have continued low fees with low-income patients, while raising fees for those able to pay.

The United Hospital Fund office said that the future was not bright as regards hospital costs. It was pointed out that many hospitals were unable to do needed repair work during the war and must now pay for it at increased prices. Furthermore, nurses and other employees, themselves afflicted with a soaring cost of living, were demanding and receiving higher wages.

### COMPENSATION BOARD

A representative of the State workmen's compensation board said that although it was paying doctors under schedules adopted before the war, the physicians were "asking for more money" and that the schedules might soon have to be changed.

The Physicians' Forum, in its informal survey, according to Paul Ziporkas, executive director, found that laboratory fees had not risen as much as other costs to doctors. But physicians complained repeatedly about the price of appliances and prosthetic devices (wooden legs, glass eyes, etc.).

A spokesman for the Committee for the Nation's Health agreed with physicians' groups that with rising medical costs people are thinking twice before going to see their doctors. All questioned the possible effect on public health if rising medical costs coupled with the increase in commodity prices keep patients away from the doctors' offices.

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[Telegram, Worcester, Mass., April 26, 1947]

## HOSPITALS HIT BLUE CROSS PAY—FOUR IN CITY SAY RATES DO NOT COVER COSTS OF PROPOSED SERVICE; CONTRACTS PENDING

(By Charles E. Currier, Telegram staff reporter)

Blue Cross has a new schedule of fees for participating hospitals, effective June 1, to pay its new comprehensive hospitalization service for subscribers.

Officials of four Worcester hospitals contended yesterday the proposed fees would not pay the actual cost of patient care and treatment at their institutions.

### REFRAIN FROM SIGNING

As a result, they have refrained from signing new participating agreements with Massachusetts Hospital Service, Inc., pending possible adjustment of the new rates.

The hospitals say Blue Cross failed to take into account increased costs of operation and supplies, especially drugs, by fixing the fees on an average of what it paid each institution in 1946 on a per-patient basis. Blue Cross patients represented between 38 and 60 percent of each of the four institutions' admissions last year.

### 100,000 IN THIS AREA

Here are more than 100,000 Blue Cross members in the Worcester area and the new plans, which would replace all contracts now in force, seek to guarantee payment of almost all hospitalization charges for their subscribers.

But the proposed fees, varying with each hospital, are not enough and the institutions have so many Blue Cross patients they cannot afford to carry them at a loss, according to officials of City, Fairlawn, Hahnemann, and St. Vincent Hospitals. They referred specifically to the care of semiprivate patients under the second Blue Cross comprehensive plan.

Dr. Winthrop B. Osgood, superintendent at Memorial Hospital, said the per daily patient fee of $9.25 proposed for semiprivate care and treatment at his institution would just about meet actual costs, but it contains no allowance for increased costs.

### PRICES SUGGESTED

City Hospital would receive $6.50 a day for semiprivate patients; St. Vincent, $7.81; Fairlawn, $8.22; and Hahnemann, $9.74. For this the hospitals would be required to furnish board and room, nursing care, medicine, operating and laboratory facilities, anesthetists, etc., it was said.

One hospital official said the fees proposed for Worcester hospitals were on the average about $4 less than those allowed Boston institutions.

### DIRECTOR COMING

Because of the objections raised, Blue Cross will send its assistant hospital relations director, Henry G. Brickman, to confer with Worcester Hospital authorities Monday.

He will meet first with Fairlawn officials, and also is expected to contact the heads of the other hospitals.

Although the letter accompanying the new agreements said the prices, proposed for the semiprivate plan and the ward plan (for members in low-income brackets), would be given a 12 months' trial, Blue Cross officials in Boston said yesterday they were still subject to negotiation. The agreements were to be signed by participating hospitals by May 1.

### FLUID NEGOTIATION

H. Proctor Redd, Blue Cross public relations director, declared at his Boston office: "I want to make it clear that these agreements are in a process of very fluid negotiation and it's up to the hospitals to bring up any new factors on which we can negotiate these fees." He said he spoke for the executive director, R. F. Cahalane.

However, one hospital official here said he went to Boston shortly after he received the proposed new agreement early this month and his plea for an adjustment of the fees met with little consideration.

Under the old Blue Cross contracts specific payments were guaranteed for specific services and any others were billed directly to the patient by the hospital.

### WARD PLAN

The hospitals have no quarrel with the fees proposed for the new comprehensive ward plan. This is available to single persons with an income of $1,500 or less, and to others with one dependent whose income is $2,000 or less, and with two or more dependents, $2,500 or less.

Persons getting more than $2,500 a year could only subscribe to the semiprivate plan.

The fee proposed for semiprivate care at City Hospital is so low that it equals the $6.50 authorized by Blue Cross to cover hospitalization of ward plan patients. Yet Dr. Huston K. Spangler, superintendent, said the per capita cost of semiprivate patients to City Hospital amounts to $9.20 a day. He has submitted the entire proposition for decision by the hospital trustees.

"I believe that City Hospital should not commit itself to a contract, calling for the payment of hospitalization of semiprivate patients, that would represent a loss to the hospital," Dr. Spangler declared. "The hospital as an instrument of the city should not be a party to any contract that might result in the loss being underwritten by public funds."

### NEW CLAUSE

He referred to a clause in the new agreement which provides that "in the event of public disaster or any other condition occasioning demands for hospital service in excess of the financial resources of the corporation (Blue Cross) the hospital agrees to accept its proportional share of a pro rata payment by the corporation to all participating hospitals as payment in full"

Should such an occasion arise, Dr. Spangler believes any such agreement would result in an even heavier loss to the hospital because of the extremely low rate already in the proposed agreement. The text of the agreement has been referred to City Solicitor Walter D. Allen for a legal ruling as to whether the hospital can make any such commitment.

Last year Blue Cross patients totaled 38 percent of the paying cases treated at City Hospital. At Fairlawn the number of such patients represented between 50 and 60 percent of those cared for; at Hahnemann 40 percent; Memorial 49.9 percent; and St. Vincent about 50 percent.

"There is considerable difficulty in attempting to arrive at an average figure that will cover full cost of hospitalization for all patients," contended Miss Erna M. Kuhn, superintendent of Hahnemann Hospital.

She said that when she came to Hahnemann 5 years ago Blue Cross patients only numbered 5 and 6 percent of the total. Now they have become a sizable economic factor to the hospital, and cannot be carried for too long a period at a loss, she said.

### DRUGS COST MORE

Miss Kuhn called attention that drugs alone have soared in price, particularly penicillin which is being used in great quantites. In fact all costs have gone up, she added.

Sister Loretto, superintendent at St. Vincent Hospital, said officials at her institution were quite concerned over the Blue Cross proposal and intended to study it carefully before signing the new agreement. The hospital authorities, she said, are particularly concerned over the fact that Blue Cross has made no provisions for extra care and medicine that may be required by a patient.

Dr. Osgood said the fee proposed for Memorial Hospital was about equal to present costs at his institution. He said that if prices of supplies and other commodities didn't go any higher his hospital would be "all right" under the plan. He said, however, he has not yet signed the agreement.

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[News, Newark, N. J., December 6, 1946]

## Hospital Plan Ups Payments—Second Increase Granted Institutions—Subscription Costs to Rise

H. Theodore Sorg, president of the Hospital Service Plan of New Jersey, yesterday announced a new increase in the schedule of payments to hospitals. The increases, which become effective January 1, represent the second boost in 2 months.

Sorg told the New Jersey Hospital Association at a meeting at Essex House yesterday the new rates "probably will necessitate an increase in subscription rates for some types of contracts."

The hospital pay boosts start with one additional dollar for a 5-day hospital stay by a subscriber, increased to $4 more for 6-day stays, $7 more for 7-, 8-, and 9-day stays, and $8 more for stays of from 10 to 21 days. Under the new schedule a hospital will get $157 for 21 days of hospitalization of a plan subscriber.

### RAISED NOVEMBER 1

Under rates in effect before November 1, hospitals got $145 for 21 days of hospitalization. Increases which became effective November 1 boosted the 21-day figure to $149. These increases upped plan payments for stays of all lengths from one to 21 days.

Under the plan announced yesterday, the credit allowed subscribers for hospital stays of over 21 days is cut from $3.63 to $3. It was not affected by the November 1 changes. Sorg said the reduction now was necessary "in order to balance our budget."

Sorg said that subscription rate increases which may follow the new hospital rates will not affect employee group contracts, paid all or in part by the employer. These contracts, he said, which encourage a high percentage of enrollment, are the most desirable for the plan. He said there are 354 employee groups out of 3,000 enrolled for which the employer pays all or part of the subscription fees.

### 900,000 ARE AFFECTED

There are now, he said, more than 900,000 individuals covered by plan contracts.

Sorg urged hospital administrators yesterday to reduce "within the limits of medical safety" the length of hospital stays. Hospitals, he said, should guard against being used for "rest cures or as an escape from a maidless home."

An increase of 1½ days in the average length of stay of subscribers, he said, "would put every hospital plan in the country out of business" because of the statistical basis on which their rates are computed.

Sorg said that the average length of stay in New Jersey hospitals increased about a half day last month.

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[Journal of Commerce, New York City, January 7, 1947]

## MAINE BLUE CROSS ANNOUNCES CHANGES IN PLAN

(Special to Journal of Commerce)

PORTLAND MAINE, Jan. 6.—Family subscribers to the Associated Hospital Service of Maine (Blue Cross) are offered their choice of a rate increase of $4.80 a year or a 25-percent reduction in dependents' benefits, under the new rate schedule just announced.

Under the increased rates, hospital benefits include some increases, including an allowance for diagnosis, liberalized obstetrical care, and improved provisions for tubercular, mental, and communicable diseases. The rate increase results from higher hospital operating costs.

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[Oregonian, Portland, Oreg., January 17, 1947]

## BLUE CROSS HIKES COSTS, BENEFITS

Blue Cross plan for prepaid hospital care Thursday simultaneously announced increased benefits and rise in fees for individual direct pay members, according to Executive Director Frank F. Dickson, Northwest Hospital Service.

Increased rates apply only to direct pay members, Dickson stated. Membership dues of group enrollees will continue at present levels. Direct pay rates for one person go from $1.25 to $1.50; two persons, from $2.35 to $3 and family, from $3.10 to $4 per month.

New hospitalization costs and increased incidence of hospital care necessitated new rates. To offset them, Blue Cross now offers an allowance of $6 a day instead of $5.50 in nonparticipating hospitals; 21 days' full benefits a year plus 180 days instead of 90 at half benefits; and maximum hospitalization each year for each illness from a separate cause.

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[Democrat and Chronicle, Rochester, N. Y., March 15, 1947]

## HOSPITAL INSURANCE DUE TO RISE—RATE INCREASE SET FOR LATER IN YEAR

Increase of $1 a day in rates charged by six Rochester hospitals, revealed yesterday, is scheduled to bring a jump in hospital insurance rates before the end of the year, it was disclosed last night.

Sherman D. Meech, managing director of the Rochester Hospital Insurance Corp., which handles both group and nongroup subscribers for hospital service, said the corporation's board will meet next week to make recommendations and then a group of officials will go to Albany to discuss contract changes with State insurance department officials.

"At the present time, we don't expect contract changes affecting rates to go into effect for 8 months," said Meech.

### PRESENT COST SET-UP

The present rate for employed groups is $9.60 a year for a single person and $22.80 for families. For nongroup subscribers the rate is $12 a year for a single person and $26 for families.

At present, there are 318,000 persons insured for hospitalization by the corporation, a net increase of 42,000 in the past year.

As a nonprofit organization with operating costs at 11 percent and a set-aside for reserve funds, increase in subscribers does not mean reduction in rates, Meech explained.

The hospital service corporation is now paying $8.50 a day for a semiprivate room. This cost includes all services except X-ray and expensive drugs.

### INSURANCE RAISED ONCE

Hospital insurance rates have been increased only once, in May, 1945, since the corporation was formed in 1935, according to Meech. At that time the amount paid hospitals was increased from $7.23 to $8 a day. Last summer, the amount paid was advanced to $8.50 and in addition the corporation paid hospitals $60,000 out of reserves to apply on 1946 costs. While the present rate of $8.50 pays only for rooms, the corporation wil lcontinue to provide the service benefits covered in contracts, Meech said.

Increase in rates at the six hospitals, General, Genesee, Highland, Park Avenue, St. Mary's and Strong Memorial, went into effect March 1, according to Charles M. Royle, executive secretary of the Rochester Hospital Council Inc. Royle said the advances were necessary because of increased costs of labor and supplies and the recent boost in food prices.

### NEW HOSPITAL RATES

The new rates are: Ward bed, $7 a day; semiprivate rooms, $8.50 a day; private room, minimium, $10; care of new-born child while the mother is in the hospital, $3. The new rates cover bed, board and routine care without extras. Care of infant after a mother leaves the hospital remains at $3 a day.

The last rate increase by Rochester hospitals occurred July 1, 1946. According to Royle, hospital costs have increased 122 percent for personal services and 58 percent for supplies compared to costs in the 1935–39 period.

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[Post-Gazette, Pittsburgh, Pa., October 17, 1946]

## Hospital Care Official Asks Cooperation—Warns Institutions That Federal Control May Be Alternative

Cooperation between hospitals and hospitalization plans to provide subscribers with full hospital care was urged last night by Abraham Oseroff, national treasurer of the Blue Cross Hospital Commission.

Mr. Oseroff warned unless such a program is followed the door will be opened to full Government control of hospitalization on a compulsory basis.

Although he also is vice president of the Hospital Service Association of Pittsburgh, Mr. Oseroff pointed out his recommendations were aimed largely at institutions outside this district. He described progress of the Blue Cross program in Pennsylvania as "much better" than in other parts of the country.

### REQUESTS COSTS REVISION

Mr. Oseroff outlined an eight-point program for revision of hospital systems of costs accounting to provide a "sound payment structure" for Blue Cross payments to hospitals.

He recommended hospitals be reimbursed in full for the cost of services provided Blue Cross subscribers but said "it is not tenable * * * that self-supporting services should bear the burden of free work done by the hospital." The cost of free services provided by hosptials, he said, should eventually be assumed almost wholly by governmental bodies and until such time should be met with governmental aid, Community Chest contributions and individual gifts.

In urging provision for full hospital case, "excepting only the luxuries surrounding private-room care," Mr. Oseroff indicated the trend toward higher payments to hospitals and higher charges to subscribers should be resisted.

### ASSAILS HIGH CHARGES

"Charges to subscribers are already, in some plans, too high to compete favorably with charges for similar services by commercial insurance companies," he said. "In other plans, too, pressure by hospitals for more money from plans is threatening to force up charges to subscribers to a point where they will scarcely better the increasingly good job which commercial companies are doing.

"The people have been told they are to receive full hospital care," he continued, "After years of operation of our plans, under hospital sponsorship, they still receive only partial care. They want even now to know why they do not yet have what is today assumed by all to be a basic need."

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[News, Philadelphia, Pa., March 31, 1947]

## BLUE CROSS INCREASE SPELLS EXTRA SERVICE

The Blue Cross Plan of the Associated Hospital Service will provide additional services for subscribers and increased payments to hospitals in return for higher rates approved by the State insurance commission, Thomas S. Gates, Jr., president of the organization, announced today.

### EFFECTIVE MAY 1

Increased payments to hospitals became effective yesterday. Contracts for new subscribers will go into effect May 1, but will not affect present members until their current contracts expire.

Effective May 1, under the new plan, a subscriber, who presently may receive 21 to 30 days' hospitalization in any one contract year, will be permitted that number of days' stay as many times as he is hospitalized if each occasion is for a different illness.

An increase from $5 to $6 a day will be allowed for private rooms; from $12 to $15 for the first day and $6 for each day thereafter in nonmember hospitals. Subscribers will also be allowed emergency accident care and minor surgery at a hospital, even though not actualy a bed patient.

### INCLUDED

All other benefits will remain identical, except maternity, which will provide $7.50 a day for 10 days instead of the present complete maternity care for 10 days, which averaged $82.50 per patient.

In addition, Blue Cross benefits will continue to include semiprivate rooms, meals, and special dietary service, general nursing service, surgical dressing, drugs, and medication, including penicillin and sulfa drugs, use of operating room, anesthesia, physical therapy, X-ray examinations up to $35, laboratory examinations up to $25, electrocardiograms up to $15, metabolism tests up to $10.

The new monthly rates for group members are for a single subscriber, $1; husband and wife, without maternity, $2; husband and wife, with maternity, $2.50; widow or widower and all unmarried children under 19 years, $2; family including husband, wife, and all unmarried children under 19 years, with maternity, $2.50.

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[News, Buffalo, N. Y., February 8, 1947]

## BLUE CROSS REPORTS $712,018 SURPLUS; SERVES 40 PERCENT OF WESTERN NEW YORK

Completing its tenth year, the Hospital Service Corp, of western New York (Blue Cross) today disclosed that it has a surplus of $712,018 after providing for all its known and anticipated liabilities.

The financial statement published today listed assets of $1,863,083. President George A. Newbury called attention to "the extraordinary growth and strong financial position that the Blue Cross has achieved in the comparatively short span of 10 years."

The Blue Cross now is providing hospitalization at cost for more than 40 percent of the population in the western New York area, he said, lauding the cooperation of 32 participating hospitals, industry, and labor.

During the past year the Blue Cross, for the first time, had to increase its rates to subscribers, to keep up with the increased cost of operating hospitals, Mr. Newbury pointed out.

The statement showed that the Blue Cross' assets consisted of $571,388 in cash, $1,139,583 in United States Government obligations, real estate to the value of $58,893 and accounts receivable of about $90,000.

"After providing for all known and anticipated liabilities in the aggregate amount of $1,151,064.34 as shown by the statement," said Mr. Newbury, "the Blue Cross has a surplus of $712,018, which is $132,959 more than the statutory requirements of the insurance law and the superintendent of insurance of the State of New York. Substantially all of this amount is held in cash and United States Government bonds. No better proof could be had of the financial integrity of the western New York Blue Cross and its ability to meet every claim that may be made upon it."

The Blue Cross recently reported on its tenth anniversary, January 15, a membership of more than 425,000 and the fact that it has paid on behalf of its members more than $10,000,000 in the past 10 years for hospitalization. It reported earned income of $2,570,000 during 1946 and the expenditure of $1,925,851 for hospital care during the past year.

Mr. Newbury pointed out that administration and acquisition or sales expense had been maintained at a very low rate, averaging about 13 percent during the 10-year period, which is only about half of the amount allowed by law.

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[PM, New York City, August 2, 1946]

## INFLATION NOTE: HOSPITAL PLAN MAY BOOST RATES

(By Amos Landman)

The Associated Hospital Service—New York's Blue Cross plan—for months now has been considering raising its rates because it's costing member hospitals more to live, Louis H. Pink, president, told PM today.

Inflation during the last 5 years has raised the hospitals' price of food, laundry service, fuel, medical supplies, as well as labor, Pink said. If inflation continues, another official of the Associated Hospital Service declared, the membership fee will also have to be raised. The extent of the increase—if it is voted—has not been decided.

Any increase will have to be approved by the State insurance department, which has the authority to disapprove rates which are "excessive, inadequate, or unfairly discriminatory."

Present rates are 80 cents a month for an individual, $1.60 for a husband and wife, and $2 for a family with children.

With about 2,600,000 subscribers in the metropolitan area, a 10-percent increase would cost members between $1,000,000 and $1,500,000 a year.

Any attempt to boost rates is expected to be opposed by the two spokesmen for organized labor on the board of directors.

Saul Mills, secretary-treasurer of the Greater New York CIO Industrial Union Council and a member of the AHS board, opposed bonus payments for the year 1945 of $400,000 above the actual cost per patient paid by AHS to hospitals. This week AHS began mailing the first installment on a $1,000,000 bonus for 1946.

Mills declared that on April 10, the directors of AHS voted the organization's six officers salary increases of $9,000 a year. Pink voted against his own raise, from $20,000 to $25,000, Mills revealed.

The CIO representative also pointed out the AHS has a surplus of nearly $6,000,000 for 1945, a reserve for epidemics and other contingencies of $3,365,000, and total assets of $16,500,000, most of it in Government bonds.

On the basis of this financial picture, Mills opposes an increase in rates. He contends that with AHS in such a favorable financial position, it should extend its benefits to members.

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I. At the one hundred and sixty-sixth annual meeting of the Massachusetts Medical Society this week (as reported in the Boston Daily Globe of May 21) Dr. McKettrick, Boston surgeon and member of the board of trustees of the National Physician Committee (which reported under the Lobbying Act spending $306,000 during the last 5 months of 1946), stated that 84 percent of the population in Massachusetts had incomes of less than $3,000 a year and could not pay the cost of serious illness. Sixty-nine percent earned less than $2,000 and this does not include the unemployed. The Blue Cross—Blue Sealed of Massachusetts according to the paper provides surgical and obstetrical care for 600,000 persons or for 13 percent for the population. Assuming that all members now covered earned less than $3,000, 71 percent of population in need of protection remain uncovered.

II. At this time, when there is every indication that unemployment will increase and earnings will decrease, the Blue Cross—Blue Sealed of Massachusetts announces substantial increases in their monthly rates effective June 1, 1947. To be covered for medical care in hospitals only, a husband and wife, with or without children will have to pay $5.50 per month or $66 a year for care in a semiprivate room and $50.40 for care in a ward. Ward service is limited to a husband and wife with income of less than $2,000 and if their incomes is $2,500 they can be charged additional fees by the physician.

III. To substantiate the claim that the cost of Blue Cross—Blue Sealed is too high for a limited service to be given under the new rates, 16 independent railroad organizations working on the Boston & Maine Railroad after making a thorough study of various plans, recommended jointly to their membership that this continuance of Blue Cross—Blue Sealed as of June 1 end the purchase of a benefit plan offered by a commercial insurance company which "offered the most benefits for the least cost".

(The commercial insurance company—the Employees Liability Insurance Corp. of Boston offers substantially the same benefits of Blue Cross—Blue Sealed, paying their physicians as well, in some instances better (appendectomy $75–$100 costs slightly less and in addition insures the employees for accidental deaths and dismemberment for the sum of $2,000.)

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[Chicago Journal of Commerce, October 23, 1946]

## BLUE CROSS PLAN FACES FIGHT FOR LIFE IN ONTARIO LEGISLATURE

TORONTO, October 28.—Ontario hospital insurance programs, including the Blue Cross system which operates both in the United States and Canada, today faced a fight for survival in the Ontario Legislature following determined attacks by a cabinet minister and a legislator.

Russell T. Kelley, the cabinet member launched a bitter attack on what he called "the high profits" enjoyed by organizations selling hospital insurance in Ontario. He predicted important changes in the provincial government's hospital policy.

Dr. R. Hobbs Taylor, a member of the legislature, also assailed present hospital insurance programs and recommended immediate imposition of direct taxation upon organizations selling such insurance.

"These schemes have greatly increased the number of hospitalizations and at the same time they build up enormous reserves," Dr. Taylor said. "The Blue Cross has made over $1,000,000 in 5 years and the municipalities have to foot the bill for the increased building program that benefits the policyholders."

Mr. Kelley said he knew of "two such companies which have made $50,000,000 in profits."

Dr. Walton McKibbon, Wingham, Ontario, physician, also attacked the high profits which he said the organizations are making, although he objected to proposals to tax them.

"They shouldn't be allowed to operate as profit-making concerns at all," he asserted.

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[Inquirer, Philadelphia, Pa., March 25, 1947]

## BLUE CROSS LIFTS RATES 30 PERCENT—INCREASE EFFECTIVE MAY 1, HIGHER HOSPITAL COSTS CITED

Subscribers' rates in the Blue Cross hospitalization plan will be increased approximately 30 percent beginning May 1, it was announced yesterday at a joint conference between the Philadelphia Hospital Council and the board of directors of the Associated Hospital Service.

The rate increases have become necessary, it was reported, due to constantly higher service payments to hospital members of the Blue Cross.

### PAYMENTS RAISED FIVE TIMES

While this is the first increase in subscriber rates since the Blue Cross was founded in Philadelphia in 1938, Thomas S. Gates, Jr., president of the Associated

Hospital Service, announced, hospital payments have been raised five times making an increase of more than 50 percent.

A new schedule of payments of hospitals for present contract-benefits provided to Blue Cross subscribers in semiprivate accommodations will become effective April 1, it was announced. These payments, on a per diem basis, will take 82 percent of the total income of the Blue Cross, as compared to a previous 79.5 percent, according to the statement issued yesterday.

### NEW RATES LISTED

Under the new schedule, monthly subscriber rates will be increased as follows:

Group enrollment—individuals, from 75 cents to $1; husband and wife without maternity benefits and widows and children, from $1.50 to $2; husband and wife, or family with maternity, from $2 to $2.50.

Nongroup subscribers—those who have left their original group and have not joined a new one, but are being billed direct to their homes; annual payments—individuals, from $10 to $13.20; husband and wife without maternity and widows and children, from $20 to $27 and husband and wife or family with maternity from $27 to $35.40.

### EFFECTIVE MAY 1

The new rates represent an approximate "across the board" increase of 30 percent, E. A. van Steenwyk, executive director of the Blue Cross, announced, but in many instances the jump is 25 percent.

While the program will become effective May 1, it was announced that subscribers will pay the added rates after the expiration date of their present yearly contract. No increase will become effective until that time, it was reported, and all subscribers will be notified.

### HOSPITALS GET MORE

The new schedule of payment to hospitals based upon the length of stay and graduated to provide higher per diem reimbursement for short stays for semiprivate cases are:

One day, $22; 5 days, $55; 10 days, $100; 21 days, $160.50; and 30 days, $210. For these amounts the hospitals agree to provide the contract-benefits stated in the subscribers' contracts, as now offered to the public, except that supplementary payments would be made to the hospitals when the cost of oxygen and drugs exceed $20 per admission.

### THREE MILLION IN RESERVE

Philadelphia is the last large city to increase the rates, it was announced, and tht added costs here also are lower than in New York and Boston. The increase here represents about 13 cents a week per family, it was explained.

Operating costs have been reduced to 12 percent, it was stated, hospital payments take 82 percent of the total and the balance is placed in reserve to be loaned to subscribers for emergencies. There is now $3,000,000 in the reserve, it was announced.

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[Herald, Boston, Mass., November 6, 1946]

## Because of Rising Hospital Costs Blue Cross Protection Is More Important to You Than Ever Before

As you well know, the cost of living has risen sharply since 1940 * * * nearly everything you buy has gone up.

This is also true of nearly everything that hospitals buy and of the wages they pay. Since most hospitals charge only enough to meet their expenses, they have been forced to charge more for their services or close their doors.

### HAVE YOU BEEN TO A HOSPITAL THIS YEAR?

If so, you are well aware of today's high cost of care. Here are some typical examples of rate increases in Massachusetts hospitals:

*Daily rates for hospital semiprivate room and board*

| | 1940 | Today | Percentage increase |
|---|---|---|---|
| Hospital A | $4.50 | $7.00 | 55.5 |
| Hospital B | 5.00 | 7.50 | 50.0 |
| Hospital C | 5.50 | 8.00 | 45.6 |
| Hospital D | 5.00 | 7.00 | 40.0 |

Many other service costs have gone up, for example:

*Charge for operating room*

| | 1940 | Today | Percentage increase |
|---|---|---|---|
| Hospital A | $10.00 | $20.00 | 100 |
| Hospital B | 5.00 | 7.50 | 50 |
| Hospital C | 20.00 | 25.00 | 25 |
| Hospital D | 12.00 | 15.00 | 25 |

And so it goes * * * in one hospital after another.

### HOW BLUE CROSS PROTECTS YOU AND YOUR FAMILY

The great advantage in holding a Blue Cross membership is that you receive all the hospital services covered in your contract regardless of cost.

### WHY ARE BLUE CROSS SUBSCRIPTION RATES STILL SO LOW?

Subscribers may rightly ask how Blue Cross has been able to pay these increased hospital costs without charging its subscribers more. The answer can be found in the tremendous growth in Blue Cross memberships during the war years. As a result, Blue Cross, in cooperation with its member hospitals, was able to meet past increased costs with greater benefits while maintaining the same rates to subscribers that were in effect before the war.

However, because of recent additional costs to hospitals it is inevitable that subscription rates will eventually have to be increased. In the meantime, Blue Cross protects its members with the full service benefits outlined in its contract instead of giving inadequate cash benefits which buy less and less care each month. If Blue Cross subscription rates are increased, you may be sure that the increase will be as small as possible since Blue Cross is nonprofit. Blue Cross protection will prove more important to you than ever.

### BLUE SHIELD PLAN

The Blue Shield is operated jointly with Blue Cross. It pays your doctor for in-hospital surgical and maternity care and allied services. Blue Shield is sponsored by your family physician and the Massachusetts Medical Society. Over 5,500 physicians in Massachusetts participate in this nonprofit medical service. Enrollment at the present time is available only through your place of employment.

With higher hospital costs—Blue Cross gives you greater protection than ever before!

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[Republican, Waterbury, Conn., August 17, 1946]

## CIO HITS NEW BLUE CROSS RATE BOOST

Waterbury CIO sources said yesterday that they might demand changes in the State insurance laws to require the Blue Cross hospital plan to open its books to any and all subscribers unless they could satisfactorily explain rate increases and benefit reductions to go into effect September 1.

The challenge was issued over the name of Armand Fiorelli, president of Local 251, Mine, Mill and Smelter Workers.

A list of specific benefits which he said were knocked out of Blue Cross policies in the new contracts was issued at the same time by Harold Senior, public relations director of the State CIO council. He said:

"Earlier contracts allowed unemployed persons to continue policies for 6 months at half cost. New policies do not make this provision.

"Children less than a month old are no longer defined as family members.

"In old contracts, Blue Cross would pay all actual hospital charges with no limitations. This is no longer so.

"Old contracts allowed members 21 days of hospitalization a year plus an additional 90 days per year for which Blue Cross would pay half the costs. New contracts allow 21 days but put a limit of $3 a day on all additional days up to 90.

"Special diets are no longer covered in Blue Cross policies.

"Delivery room service is not mentioned in new contracts.

"Care for new-born infants has been eliminated.

"New contracts give out-patients only $7.50 per case in contrast to former unlimited allowances.

"In maternity cases the Blue Cross will pay only $65. There was no limit previously.

"Emergency ambulance service has been eliminated. A member was previously allowed $8 for this.

"The provision has been canceled which allowed members to go to hospitals for diagnostic study."

(Editor's Note: Under the bylaws of Connecticut Blue Cross, "members of the corporation shall be the incorporators and such persons as may from time to time be elected at the annual meeting or a special meeting of the corporation."

(While persons covered by Blue Cross contracts are alluded to as "members," they are, in effect, subscribers to the hospital plan service which Blue Cross provides.)

Mr. Fiorelli's statement follows:

"CIO members who are members of the Blue Cross hospital plan are today demanding of the Blue Cross a complete and detailed statement as to the reasons for recently increasing the cost of the plan by 30 percent while at the same time drastically reducing the benefits.

"CIO members resent the Blue Cross' habit of acting in the manner of a closed corporation advising members of radical changes in policy without prior consultation. We are shocked by the complete lack of democracy in Blue Cross and if changes are not voluntarily forthcoming from the bureaucracy of that organization we shall seek remedy through the State insurance laws. Meanwhile our conviction grows that what the people of this State and Nation need is President Truman's national health program which would provide complete medical hospital and dental care to all Americans at much less than the cost of the incomplete and uncertain medical care which most Americans now receive."

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[Monitor, Concord, N. H., November 6, 1946]

## WITH THIS CARD IN YOUR POCKET YOU CAN QUIT WORRYING ABOUT HOSPITAL AND DOCTORS' BILLS

BLUE CROSS

*Nonprofit hospital-surgical-medical services*

BLUE SHIELD

1. Prepays your hospital bills.
2. Provides substantial allowances toward surgical expenses when an operation is necessary.
3. Provides generous allowances toward bills rendered by your family doctor for regular medical care.

Concord's hospitals are supporting members of Blue Cross. Concord's physicians are participants in Blue Shield.

*Get further details at Concord Chamber of Commerce*

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[Berkshire Eagle, Pittsfield, Mass., August 14, 1946]

## BLUE CROSS PROTECTS YOU AGAINST RISING HOSPITAL COSTS—SOME HOSPITAL CHARGES IN MASSACHUSETTS ARE UP 25 TO 50 PERCENT OVER 1944

Rooms, meals, medications * * * these hospital services now cost patients more because they cost the hospitals more.

At one Massachusetts hospital, a semiprivate room which cost $4 a day before the war now costs $8. Others have had to increase rates proportionately.

With hospital costs up and still going up everywhere, a Blue Cross membership is more valuable than it ever was before.

For Blue Cross charges you only a few cents a day—and guarantees you all the services which are covered in your Blue Cross contract regardless of how far they may have advanced in cost.

Blue Cross is the only plant that can do this because it pays the hospital for the services given you instead of making a limited cash allowance. Blue Cross is the only nonprofit plan in Massachusetts. It spreads the risk at low cost, gives you protection against the rising costs of hospitalization.

Be prepared when an accident or illness strikes. Mail the coupon below for full information today.

THE CHANCES ARE 1 TO 10 THAT YOU WILL GO TO THE HOSPITAL WITHIN A YEAR

*For further information mail this coupon today. It may save you a large hospital bill!*

BLUE CROSS—M-4415
38 Chauncy Street, Boston 11, Mass.

I am interested in obtaining the protection that membership in the Blue Cross Plan provides. Please forward further information.

Name______________________________________

Address____________________________________

Name of company where employed____________________

Address of employer____________________________

Check if one applies: ☐ self-employed ☐ retired ☐ unemployed

Date employed________________ Number of employees________

(This is not an application. Do not send payment.)

*Nonprofit Blue Cross pays a hospital bill every 18 seconds in the United States of America*

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[Star, Washington, D. C., June 18, 1946]

## MEDICAL CARE PREPAYMENT PLAN GROWS RAPIDLY IN BAY STATE

(By Harold B. Rogers)

BOSTON, June 18.—While the District Medical Society is on the verge of taking action on a new prepayment plan to help the average citizen of Washington pay his surgeon for an operation, an organization already is doing almost exactly the same thing, probably more comprehensively, here in the Bay State.

The plan here, known popularly as "Blue Shield" (for surgeon's bills) is separate from "Blue Cross" (for hospital bills). But the two are administered jointly to save expense.

In Washington the movement to help the public pay more easily for medical care of all kinds has been a subject of some controversy for years. But it will reach an important turning point tomorrow night, when the District Medical Society meets to take action on a long-pending proposal.

For this reason, the success of both Blue Cross and Blue Shield in Massachusetts are of timely interest to the National Capital community. The Bay State plans have attracted Nation-wide attention.

The Boston plan and other voluntary systems for medical and hospital care, sponsored by the organized medical profession itself, are being pointed to by champions of private practice, including the American Medical Association, as the logical answer to demand from other quarters for compulsory national health insurance. The issues are being debated in congressional hearings on the pending Wagner-Murray-Dingell bill to amend the Social Security Act.

A vote is to be taken tomorrow night in Washington on adoption of a limited prepayment medical service plan, deevloped and recommended by the District Medical Society's committee on medical care, headed by Dr. Frank D. Costenbader. It is the result of about 2 years' study and extensive hearings. It is designed to set up a plan for monthly installment payments to defray the cost of certain surgical and obstetrical services, supplemented by laboratory, X-ray, and anesthesia fees, in the hospital only. Details have not been disclosed.

The proposal has been named Medical Service of the District of Columbia. If approved, it is expected to be implemented by a new corporation and probably would be administered by Group Hospitalization, Inc., a nonprofit hospital service plan which has more than 50,000 participants already under protection for hospital bills.

The Blue Shield here, known officially as Massachusetts Medical Service, is sponsored by the Massachusetts Medical Society, and already has more than 250,000 subscribers. It is growing swiftly, at the rate of about 30,000 a month, officials told this correspondent.

How does Blue Shield work?

At present, according to R. F. Cahalane, executive director, it is a "nonprofit, low-cost surgical care plan sponsored by doctors to provide protection for all the family." It may be expanded soon. It receives monthly payments from subscribers, who in return get certain specified obstetrical and surgical care, X-rays, and other benefits rendered by participating physicians. These physicians include four out of every five doctors in Massachusetts, Mr. Cahalane said.

"Do I have a free choice of physicians?" is one question often asked by the public, and printed for the public's benefit in one of Blue Shield's brochures.

### CHOICE OF PARTICIPANTS

"You have a free choice of a participating physician," is the answer.

"What is a participating physician?"

"He is one who has entered into a contract with the Blue Shield to furnish surgical and certain other services to Blue Shield members. A list of Blue Shield physicians is available on request."

Blue Cross and Blue Shield have increased so rapidly and successfully throughout this State that they have outgrown their present joint headquarters and have had to buy a building of their own to get sufficient room for employees. The staff has been increased to 800 people.

So practical has the surgical program of Blue Shield become that based on sound actual experience, it is expanding to offer more service, Mr. Cahalane said, including medical care.

People subscribing to Blue Cross, under the Massachusetts plan have the free choice of any of the 151 member hospitals in the State, " or any general hospital in the world."

### INDIVIDUALS OR GROUPS

Blue Cross members who also join Blue Shield have the choice of 4,300 participating physicians out of the 5,500 registered in the entire State.

Blue Cross accepts subscribers in groups, and during special campaigns, accepts individuals. Blue Shield also accepts subscribers only in groups, except during campaigns.

What does it cost?

Blue Cross hospitalization costs an individual 85 cents a month for semiprivate accommodations and 60 cents a month for service in a ward. For a husband and wife, semiprivate service is $1.65 a month, and ward, $1. For a family, including husband, wife and all unmarried children under 19, it is $2 for semiprivate plan and $1.25 for ward service. Benefits for each family member include, among other things, 30 days of hospital care for "each admission" and a "credit of 50 percent of the cost of services listed for an additional 90 days each admission."

### MONTHLY RATES ARE EQUAL

The monthly rates for Blue Shield are the same as for the Blue Cross semiprivate plan. If a subscriber takes both, his total bill for each month, protecting him for both hospital and surgeon's bills would be for the individual, $1.70; husband and wife, $3.30; and family, $4.

Blue Shield for these monthly dues will "pay your participating physician for the following professional services":

Surgical operations for disease and injury; obstertrics, including normal delivery, miscarriage and caesarean section—but does not include prenatal or postnatal care; anaesthesia, when administered for surgical and other included services; X-rays, up to $15 when taken by the participating physician within 30 days prior to surgery, and relative to the surgical services provided; treatment of fractures and dislocations; endoscopy, when performed immediately preceding surgical services." These services are available for three weeks per hospital admission for any one ailment. There is a more "comprehensive," more costly Blue Cross plan.

### INCOME IS FACTOR

Eligibility to join the Blue Cross ward plan is based on the individual's income. Subscribers with incomes in excess of certain fixed eligibility limits, for Blue Shield, it is explained, "may be charged by the doctor with the difference, if any, between his fee and the amount specified in the official Blue Shield fee schedule." which he receives from the pool of Blue Shield funds.

On the subject of this possible additional fee which could be charged by the doctor directly to the patient, a spokesman for Blue Shield said physicians had acted with considerable restraint in adjusting such additional fees to the patients' ability to pay.

Leaders of Group Health Association and other consumer-sponsored groups for medical and hospital care are supporting the pending Wagner-Murray-Dingell bill for expansion of social security. Leaders of the organized medical profession and the Blue Cross and Blue Seal groups are opposing the Wagner bill.

There are 44 Blue Cross plans in the country which, with some affiliated Blue Shield plans, offer surgical or medical care or both.

Both Blue Cross and Blue Shield are operating in the Virginia counties contiguous to Washington. Blue Cross operates in Maryland counties near the Capital, but is now in process of setting up a Blue Shield for surgical care in cooperation with the Maryland State Medical Society.

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[Times-Picayune, New Orleans, La., September 11, 1946]

## AT LAST—HOSPITAL INSURANCE FOR ALL!

3 cents a day to age 70 pays up to $330.
Will not cancel for change of employment.
All hospitals in U. S. or Canada.
Covers childbirth, sickness, disease, accident.

Mail for free details. National Hospital Service Association, Divisional Offices 53, Fifth Floor, Carondelet Bldg., New Orleans, La.

Please send me free details about new 3-cents-a-day policy.

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[Herald, Boston, Mass., January 16, 1946]

## BLUE CROSS NOW PROTECTS 20,000,000 FROM HOSPITAL BILLS—1 OUT OF 3 IN MASSACHUSETTS

Are you a member?

Blue Cross is sweeping the Nation. Already, more than 20,000,000 Americans—one out of every seven—have Blue Cross prepaid protection, freedom from worry over unexpected hospital expense. More than 12,000 persons are joining daily. Thousands are members in your own community.

### LOW COST, NONPROFIT

Blue Cross is a low-cost, nonprofit, voluntary plan. For remarkably small monthly payments—a few cents a day—it pays the hospital for services to the entire family.

The chances are 1 to 10 that you will go to the hospital within a year—even greater that some member of your family will go. Blue Cross spreads your risk over a large number of people and assumes financial responsibilities no individual can afford to assume.

### ENDORSED BY HOSPITALS

Blue Cross is the only plan endorsed by leading hospitals. It is made possible by hospitals, leading employers, and leaders of your community. Being nonprofit, it gives you far more for your money.

Most illnesses give so little warning that heads of families seldom have the opportunity to prepare for large hospital expenses. As a result, 9 out of 10 persons have trouble getting together enough money to pay hospital bills. If you join Blue Cross, you need not worry about the bill. It will be sent directly to Blue Cross and Blue Cross will pay the hospital.

The chances are 1 to 10 that you will go to the hospital within a year.

Blue Cross is sweeping the Nation! 1,400,000 in this State alone; 20,000,000 members coast to coast; 12,000 are joining daily; 3,500 member hospitals.

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[Oregon Journal, Portland, Oreg., October 13, 1946]

## BLUE CROSS PAYS HOSPITAL BILLS FOR YOU AND YOUR FAMILY!—ARE YOU PROTECTED?

More than 23,000,000 Americans, many of them in your own community, have Blue Cross protection—freedom from worry over unexpected hospital expense. Already, one out of every six persons is a Blue Cross member and thousands more are joining daily.

Blue Cross is a low-cost, nonprofit, entirely voluntary plan for protection against hospital expense. For remarkably small monthly payments—a few cents a day—it pays the hospital for services to the entire family.

### ENDORSED BY HOSPITALS

Blue Cross is the only plan endorsed by the American Hospital Association and leading hospitals. It is made possible through the cooperation of your community hospital, leading employers, and the leaders of your community.

The chances are 1 to 10 that you will go to the hospital within a year—even greater that some member of your family will go. But Blue Cross spreads your risk over a large number of people and assumes financial responsibilities no individual could assume alone.

### LIBERAL BENEFITS

Most illnesses strike so suddenly that heads of families have little time to prepare adequately for hospital expense. As a result, 9 out of 10 people have trouble getting together enough money to pay their hospital bill.

### BLUE CROSS PAYS HOSPITAL

If you join Blue Cross, you need not worry about the bill.

You simply show your Blue Cross card to the hospital—the hospital sends the bill direct to the Blue Cross and Blue Cross pays the hospital.

Do not risk serious financial inconvenience if illness strikes in your family. Mail coupon today!

### MEDICAL AND SURGICAL BENEFITS

Available to employee groups of five or more: Medical and surgical benefits for the whole family incident to hospitalization, including treatment of dislocations, reduction of fractures, and obstetrical service and help to pay your doctor bill. The chances are 1 to 10 that you will go to the hospital within a year!

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[Journal and Star, Lincoln, Nebr., April 13, 1947]

## HOSPITALIZED WITHOUT WARNING—BUT BLUE CROSS AND BLUE SHIELD HAVE REMOVED FINANCIAL WORRY

You, too, can provide in advance for doctor and hospital bills without hardship, by enrolling now, in the Blue Cross and Blue Shield Plans. Being nonprofit organizations, Blue Cross and Blue Shield Plans give you far more for your money than any other plan. Group enrollment spreads the cost over a great many people; so that with the magic of averages, doctor and hospital bills are met in a way that few families could meet otherwise.

### MEMBERSHIP AVAILABLE THROUGH GROUPS OF EMPLOYEES OR ORGANIZATIONS

Blue Cross for hospital care (Associated Hospital Service). Blue Cross, the only plan endorsed by the American Medical Association and Nebraska's hospitals, pays all or a major part of your hospital bill for you. Over 26,000,000 Americans, over 85,000 in Nebraska, now have Blue Cross protection.

Blue Shield for medical care (Nebraska Medical Service). Blue Shield provides benefits for surgical, obstetrical, X-ray, and in-hospital medical care. It is low cost, nonprofit, and voluntary. Blue Shield is the only plan officially endorsed by Nebraska's physicians and the American Medical Association.

For information on how you can have protection for your entire family—mail coupon today.

If you are an employee, ask if your company has Blue Cross and Blue Shield. If not, mail the coupon.

If you are an employer, mail in the coupon for information on how your employees can be protected. If three or more persons are employed, a Blue Cross and Blue Shield group may be organized.

If you are a farmer, mail in the coupon, stating rural organization of which you are a member.

*A Community Health Program*

Senator SMITH. Are there any further questions?

Senator DONNELL. I have just a few. I observe it is not so far from the time we will have to leave. I am glad the Senator from Florida has recognized the reliability of Republican papers by quoting from them.

Mr. Ketchum, I want to ask you just a very few questions. There is appended to your statement a 15-page list of fees which are in force, as I understand it, between the Michigan Medical Service and the Veterans' Bureau.

Mr. KETCHUM. That is right.

Senator DONNELL. I will ask you, Mr. Ketchum, whether or not that schedule of fees is higher than the normal rates charged by doctors in your State for similar services?

Mr. KETCHUM. That would be a very difficult question to answer, Senator, except that the fee schedules are established by a committee of physicians representing State societies for that purpose, and it is presumably the average fee charged and collected by physicians throughout the State of Michigan.

Senator DONNELL. Is it your understanding that substantially that is true?

Mr. KETCHUM. Yes, sir.

Senator DONNELL. That that is the average fee charged by physicians over the State?

Mr. KETCHUM. That was the intention, I believe, honestly carried out by the committee.

Senator DONNELL. You do not believe there has been any exorbitant series of charges made by the Michigan Medical Service to the Veterans' Administration? Am I right in that?

Mr. KETCHUM. That is right. I would like to clear up one point, which I think is important for the record: That the fees set forth in that schedule include an additional amount to represent Michigan Medical Service overhead in handling Veterans' Administration programs.

Senator DONNELL. And the contract between the Michigan Medical Service and the Veterans' Administration contains a warranty reading as follows:

> The Michigan Medical Service warrants that the rates charged herein are not in excess of the rates charged other persons who are not Veterans' Administration beneficiaries for the same services.

Mr. KETCHUM. That is right.

Senator DONNELL. And in advance of the sentence which I have just read is this sentence:

> Michigan Medical Service contemplates the performance of this contract will be without profit to it, and if operating results are at variance with its intention, revisions will be proposed to produce such a nonprofit operation.

Mr. KETCHUM. That is right.

Senator DONNELL. That relates to the charges for the medical service?

Mr. KETCHUM. For our overhead.

Senator DONNELL. So that, neither from the standpoint of the charges for doctors' service nor from the standpoint of overhead charges do you consider that there has been any exorbitant charge made for the Michigan medical service?

Mr. KETCHUM. That is right.

Senator DONNELL. Reference was made in some of these clippings that Senator Pepper has offered here this morning to an increase in the cost of hospitalization. That is not the only thing that has increased in cost; is it?

Mr. KETCHUM. As a matter of fact, I might point out that part of the increase is due, in fact, to the CIO itself, where they have unions in hospitals—unions of hospital employees who recently have secured large increases in wage rates.

Senator DONNELL. Now, Mr. Ketchum, you are not a doctor, I believe?

Mr. KETCHUM. No, sir.

Senator DONNELL. Have you had occasion to observe the ordinary length of time that is consumed in the making of a comprehensive examination in the nature of an annual check-up by a doctor?

Mr. KETCHUM. Yes; because within 60 days I had one myself, and it took something like 5 hours.

Senator DONNELL. Around 5 hours. Well, you thought you got a pretty good job; did you?

Mr. KETCHUM. A pretty swell job.

Senator DONNELL. Would you think that 3 hours would be an unreasonable time to estimate as the time that would be required for a thorough check-up, on the average?

Mr. KETCHUM. Well, 3 hours would be a pretty cursory examination—not a thorough job.

Senator DONNELL. You think perhaps it would be closer to 4 hours?

Mr. KETCHUM. I would say so.

Senator DONNELL. Well, let us say 4 hours. Four hours for every person in the United States would figure up to 560,000,000 hours, if you just had one of those check-ups a year. Four hours times 140,000,000 would be 560,000,000 hours. I want you to check me on that. You make the same multiplication, do you?

Mr. KETCHUM. I am not qualified in higher mathematics. When you get into astronomical figures I don't believe I could follow it.

Senator DONNELL. Well, it is 560,000,000 hours. It is my understanding that there are somewhere around 125,000 practicing physicians in this country. If you would take a 40-hour week for each of those physicians on the average, that would figure in the neighborhood of 2,000 hours a year. It is a little bit over that—and I cannot myself multiply these rapidly, so I am going to figure it at 2,000 hours a year at a 40-hour workweek for a doctor. Now, if you multiply 2,000 hours times the 125,000, the suggested number of physicians, you would derive 250,000,000 work hours per year for all the doctors in the United States who are practicing, or for good measure, just add on a fifth more, and you would have, at something over 40 hours a week, 300,000,000 hours, and have all these doctors working longer than the traditional 40-hour workweek, for which I know Senator Pepper is strong—perhaps he favors less working hours than that.

Mr. KETCHUM. For doctors?

Senator DONNELL. For doctors.

Senator SMITH. How about time and a half for overtime?

Senator DONNELL. Yes; that should be granted, too.

Senator PEPPER. And double time on Sundays.

Senator DONNELL. That would mean, Mr. Ketchum, would it not, that if all the physicians in this country who are practicing should devote, on an average, 48 hours a week per doctor—I think my figuring is right, subject to correction—anyway, we can easily figure it out—you would have 300,000,000 hours, which is all that the doctors could devote to their work at somewhere around 48 hours a week, as I figure it; whereas, to devote 4 hours to an annual check-up for everyone of the 140,000,000 people in this country would require 560,000,000 work hours, or pretty nearly twice all the available work time of all the doctors in the United States, figured at around 8 hours a day.

I am pointing that out to you for your consideration, Mr. Ketchum, in order that you may advise us from your experience with the hospital association whether you think it is practicable to make any guaranty in any legislation of an annual check-up of 4 hours per person throughout the United States—any annual check-up of the general type that I take it Senator Pepper has in mind. Do you think that is practicable?

Mr. KETCHUM. I would like to say this: that I believe if this bill is sold to the public, the so-called Wagner-Murray-Dingell bill—if that is sold to the public, as an attempt has been made to sell recently such bill, it would be a fraud on the public.

Senator DONNELL. Obviously it is impossible to guarantee everybody in the United States a 4-hour check-up on the figures that I have submitted here; is it not?

Mr. KETCHUM. That is right.

Senator DONNELL. That is all.

Senator SMITH. I wish to make this comment. With regard to the letter addresed to the Senate Labor and Welfare Committee, dated May 21, 1947, from George F. Addes, secretary-treasurer, International Union, UAW-CIO, that up to this morning, May 23, 1947, the committee had not received this letter, I am advised by the clerk. But that does not mean we may not get it today. Senator Pepper read the letter today, so obviously he received it, but the rest of us have not received it. That does not mean that we will not give it full attention when it comes in. And I would like to advise Mr. Ketchum that he may enter in the record any answer that he cares to make on that point, or make any further comment other than what he has already made.

Mr. KETCHUM. I don't believe it is necessary, Senator.

Senator PEPPER. Mr. Ketchum, I believe you stated that that was substantially the letter he wrote last year?

Mr. KETCHUM. Yes.

Senator PEPPER. That does represent the view of the CIO—the official view—so far as you are able to say?

Mr. KETCHUM. Yes.

Senator SMITH. Did you testify with regard to that last year at the time the Wagner-Murray-Dingell bill was up for consideration?

Mr. KETCHUM. Yes. Apparently it is the same comment, probably brought up to date.

(Mr. Ketchum's brief is as follows:)

## STATEMENT BY JAY C. KETCHUM, EXECUTIVE VICE PRESIDENT, MICHIGAN MEDICAL SERVICE, DETROIT, MICH.

This statement is made from the point of view of the administration of the voluntary health care plan and is limited to an expression of opinion regarding portions of S. 545, particularly sections 712 (a) and 306.

The voluntary health care plans, such as the so-called Blue Cross and Blue Shield Plans (in Michigan, Michigan Medical Service, and Michigan Hospital Service), have demonstrated the feasibility of providing prepayment of budgeting for or insurance against the costs of hospitalization and medical care among families or individuals enjoying more than minimum incomes. There have been rapid advances in technique and methods employed in making such protection available to all classes of the population, resulting in greatly increased numbers covered as well as in a broadening of the types and extent of protection afforded by these plans. Others will undoubtedly testify here with accuracy as to the numbers now covered by such plans throughout the United States, as to the organization of plans in areas not previously served, and the nature of the benefits afforded by the various plans throughout the country.

It is obvious that families and individuals in the extreme low-income classes have not been included in the protection of these plans except as they may be from time to time employed where such benefits are automatically included as a perquisite in connection with such employment. The plans, being compelled to operate on a sound actuarial basis, without benefit of contribution or subsidy, have been unable to grant to these so-called medically indigent and welfare classes either cut rates or free protection.

Negotiations have been carried on in Michigan with certain county boards of supervisors and welfare boards with a view to arranging for the protection of the prepayment plans of Michigan Medical Service and Michigan Hospital Service (commonly called the Blue Cross Plans of Michigan) for the medically indigent. Similar negotiations have been carried on by plans in other areas.

These negotiations have failed, at least in Michigan, in every case for one or another of several reasons:

(1) In adequate county welfare funds to provide for the care required by the welfare load and the medically indigent load. It has been fairly common practice for such units to purchase such care as needed at agreed fee schedules, as long as funds were available, and thereafter to rely on the charity of the individual physician or hospital to provide needed care. This results in the necessity for the physician or the hospital, if he or it is to continue to provide such care, recouping his or its losses in such cases by spreading the cost of service among those able to pay, which is in effect only a form of general taxation. In some areas such care is purchased on an annual lump-sum basis, sometimes on a fee basis, through arrangements with county medical society groups and local hospitals, sometimes by contract with individual physicians or individual hospitals for the servicing of the entire welfare or indigency loads. In such arrangements there is an unlimited number of variations as to the details and undoubtedly as to the nature of the services rendered—both as to quantity and quality. At best, inadequacy of funds in these cases certiainly influences the quantity of medical and hospital care available.

(2) Application of the insurance principle to the problems of the medically indigent, as differentiated from the clearly defined welfare load, appears impossible, even though adequate funds may be available, due to the inability of the various governmental units to forsee the needs. Whereas the welfare load is possible of evaluation for any reasonable period of time on an actuarial basis, the so-called medically indigent, with income and funds adequate for ordinary needs, becomes a responsibility of Government only at the time of an emergency; in this case, a health emergency. It is therefore impossible for the insurance or plan actuary to promulgate a charge for coverage or insurance of this class.

(3) There is in many cases the possibility of assigning the responsibility for care of a welfare or medically indigent to some special fund or statutory health care activity of some other governmental unit, resulting in a reluctance on the part of the local county or welfare board to accept a broad responsibility, in advance of demand, for its people. These conditions arise due to a lack of coordination in the planning and operation between various units and departments of government in the various fields of health care as regards specific services or classes of people.

The provisions of S. 545, title VII, appear designed to require (712 (a) (7)) a survey or inventory of existing health care, medical, surgical, and hospital facilities; (8) continuing reports, and (9) continuing review of operations: (712 (a) (1)) the designation of a single State agency as the sole agency for supervision of administration, etc., etc.

The provision of these and other sections should result in integration and coordination of all health services within a State and between all units of government in regard to planning for, responsibility for, and provision of health care for all types of cases and all classes of medically indigent.

The financial grants provided for under S. 545, if enacted and a State plan adopted thereunder, should provide units responsible for such care which comply with the requirements of the act and the State plan with much more adequate means of providing care which previously may not have been within the financial means of the local unit.

While it is admittedly impossible to apply the insurance principle to the border-line medically indigent, the clearly welfare cases are possible of inclusion under insurance or prepayment plans.

Techniques have been developed to provide service through voluntary health care plans for groups of individuals whose health care is the responsibility of government. Plans have been in operation for some 18 months or more providing care to veterans in the home, physician's office, or hospital, for service-connected disabilities, disability pension determination examinations, and emergency care. These arrangements are based on a so-called cost-plus operation whereby the health care plan provides the services of its participating physicians and hospitals with free choice for the recipient, at an agreed upon schedule of fees, and costs with an amount added to cover only the overhead expenses of the plan. An example of this type of service is the agreement between the Veterans' Administration and Michigan Medical Service, a copy of which is attached, including the agreed upon fee schedule. It should be noted that this arrangement provides for complete free choice of physician by the veteran recipient among those physicians participating in the plan. In Michigan, the acceptance of this arrangement by the profession includes practically all of the practicing physicians rendering the type of care required for such cases Some 4,300 physicians have signed agreements to render this care in accordance with the plan out of a total of approximately 5,200 physicians licensed in the State, which latter figure includes physicians practicing specialities not called upon in this program, as well as those engaged only in research, teaching, and administrative work.

S. 545, section 712 (a) (4) permits such cost-plus operation in the Veterans' Administration program and the provision of medical care to indigents which is not possible to accomplish under any existing welfare statutes or regulations.

*Section 306.*—One of the major difficulties encountered by voluntary health care plans in extending the benefits of their coverage to more people has been the refusal of Federal Government departments, bureaus, agencies, etc., to permit the deduction from pay roll of employee's rate, subscription fee, or premium to a voluntary nonprofit health insurance fund. The refusal of the Government to allow such pay-roll deduction has rendered extremely difficult satisfactory arrangements for coverage of governmental employees, their wives and dependents. It is difficult to understand the inconsistency of the Government as expressed by this attitude when the Government itself is the greates proponent of the practice of pay-roll deduction in connection with income tax "pay-as-you-go" deductions, defense-bond sale deductions, etc.

Even though enactment of S. 545, which would seem of great benefit to the people of the United States, should fail, it is of vital importance to the employees of the Government in its various departments, bureaus, agencies, etc., and the voluntary health care plan movement in the United States that some provision similar to section 306 of S. 545 be enacted during the present session of Congress.

Attached hereto are statements in connection with the operation of the Veterans' Administration program under the agreement with Michigan Medical Service in the State of Michigan.

### EXHIBIT 1

*Michigan medical service—Authorizations received through Veterans' Administration*

| Month | Medical | | | Hospital | Total |
|---|---|---|---|---|---|
| | Treatments | Examinations | Total | | |
| 1946—March | 538 | 1, 000 | 1, 538 | | 1, 538 |
| April | 1, 802 | 3, 220 | 5, 022 | | 5, 022 |
| May | 2, 902 | 1, 275 | 4, 177 | | 4, 177 |
| June | 3, 015 | 1, 293 | 4, 308 | | 4, 308 |
| July | 3, 835 | 5, 534 | 9, 369 | | 9, 369 |
| August | 3, 009 | 1, 780 | 4, 789 | | 4, 789 |
| September | 6, 763 | 1, 105 | 7, 868 | | 7, 868 |
| October | 5, 500 | 1, 523 | 7, 023 | | 7, 023 |
| November | 3, 571 | 2, 064 | 5, 635 | | 5, 635 |
| December | 3, 010 | 1, 930 | 4, 940 | | 4, 940 |
| 1947—January | 5, 360 | 2, 893. | 8, 253 | 593 | 8. 846 |
| February | 6, 027 | 1, 697 | 7, 724 | 432 | 8, 156 |
| March | 6, 452 | 2, 732 | 9, 184 | 619 | 9, 803 |
| April | 5, 994 | 2, 371 | 8, 365 | 689 | 9, 054 |
| May 1–19 | 3, 075 | 1, 274 | 4, 349 | 313 | 4, 662 |
| Total | 60, 853 | 31, 691 | 92, 544 | 2, 646 | 95, 190 |

Professional participation: Doctors registered in Wayne, 1,887; doctors outside of Wayne, 2,386; total doctors registered in Michigan, 4,273.

MICHIGAN MEDICAL SERVICE

*Summary of operations, Veterans' Administration agreement*

Inception Mar. 1, 1946, to Mar. 31, 1947

| | |
|---|---|
| Services rendered and billed to Veterans' Administration | $708, 414. 35 |
| Expenses billed to Veterans' Administration (6.693 percent) | 47, 415. 03 |
| Total billed | 755, 829. 38 |
| Received from Veterans' Administration | 414, 580. 88 |
| Balance due to March 31, 1947 | 341, 248. 50 |

Payments to physicians for Veterans' Administration authorized services are made by Michigan Medical Service within an average of 16 days, billed to Veterans' Administration on an average of 10 days from receipt of report of service.

Michigan Medical Service secures and maintains participation of physicians in the program with distribution among the various medical specialties as well as geographically throughout the state. Approximately 90 percent of the available practicing physicians are participating. Michigan Medical Service assumes the responsibility for adequate and accurate reports of services and examinations, and provides necessary personnel in the field to instruct the physician as to completion of required reports and the methods of examinations.

Michigan Medical Service verifies authorization for services rendered; issues checks in payment therefor, advancing its own funds (to the extent of $341,248.50 on March 31, 1947) ; maintains permanent records of service reports on microfilms; compiles, maintains, and reports to Internal Revenue Department payments to individual physicians.

Billings to the Veterans' Administration are made daily in the form required by the Veterans' Administration.

Many other smaller incidental operations are carried on in connection with the Veterans' Administration program. It is submitted that the expense of the program to the Veterans' Administration is less than would be possible otherwise to secure the same results; that Michigan Medical Service has billed considerably less than the expense percentage allowable, and as the program develops even that percent will be reduced. The program has been criticized for making possible abuse through excessive utilization of services. It is interesting to note that from March 1 through August 31, 1946, of 31,060 treatments authorized by Veterans' Administration through Michigan Medical Service, 66.13 percent or 20,539 were rendered, 8.94 percent or 2,777 were not presented to the physician by the veteran, and 24.93 percent or 7,744 were canceled unused by the physician as not required.

Examinations for pension or disability rating purposes are entirely under the control of the Veterans' Administration and do not lend themselves to abuse by the physician.

December 27, 1945.

*To the Administrator of Veterans' Affairs:*

The Michigan Medical Service agrees to make available during the fiscal year ending June 30, 1946, all services outlined below in accordance with the terms and conditions hereinafter prescribed:

(1) The Michigan Medical Service will arrange, through physicians registered with it for the rendition of the medical services covered by this agreement, for examinations, treatments, and counsel in such cases as may be authorized by the Veterans' Administration, Michigan Medical Service, reserving the right, however, to decline any particular case.

(2) The Veterans' Administration will authorize examinations, treatments, and counsel. Authorizations for such services will be issued to the Michigan Medical Service; the Michigan Medical Service will advise the veteran to report to a physician of the veteran's selection in his community, such selection to be limited to those physicians registered with the Michigan Medical Service for the rendition of services under this agreement.

(3) The Michigan Medical Service will be responsible to see that reports required by the Veterans' Administration are in proper form and that proper records are maintained which will be available for review by the Veterans' Administration at any time. The Veterans' Administration will review reports of services and will return to Michigan Medical Service for further action, without additional cost to the Veterans' Administration, those which do not meet the requirements of the Veterans' Administration.

(4) Fees for medical services will be in accordance with the fee schedule, which is attached hereto and made a part of this contract. It is understood that unusually involved cases and services not scheduled will be subject to review and recommendation by Michigan Medical Service to the Veterans' Administration for determination of appropriate fee.

(5) The Michigan Medical Service will make payment to the individual physicians for services rendered on all cases in which authorizations have been issued and will in turn bill the Veterans' Administration at the end of each month. Veterans' Administration will remit in accordance with such bill within a reasonable time after receipt thereof.

(6) The Michigan Medical Service contemplates that the performance of this contract will be without profit to it, and if operating results are at variance with

this intention revisions will be proposed to produce such a nonprofit operation.

The Michigan Medical Service warrants that the rates charged herein are not in excess of the rates charged other persons who are not Veterans' Administration beneficiaries for the same services.

It is impossible to determine the exact or estimated amount which will be expended under this contract. However, it is understood that upon acceptance of this proposal the Veterans' Administration will issue authorizations for such services as are necessary and Michigan Medical Service will carry out its undertaking hereunder.

This contract shall become effective as of January 15, 1946, and may be terminated by either party by giving thirty (30) days' written notice to that effect.

This contract, if mutually satisfactory, may be renewed indefinitely for periods of one (1) year each, upon notice in writing to the contractor at least sixty (60) days prior to the expiration of each period of one (1) year, and written statement from the contractor within thirty (30) days after such notification agreeing to the renewal.

Notice to bidders: Prices bid should include any applicable Federal excise taxes, as the United States is not exempt from payments of such taxes.

No Member of or Delegate to Congress, or Resident Commissioner, shall be admitted to any share or part of this contract or to any benefit that may arise therefrom unless it be made with a corporation for its general benefit.

Michigan Medical Service agrees that in performing this contract it will not discriminate against any employee or applicant for employment because of race, creed, color, or national origin, and that it will include a similar provision in all of its subcontracts.

MICHIGAN MEDICAL SERVICE,
By ____________________________
____________________________
(Title)

Approved and accepted.

VETERANS' ADMINISTRATION,
R. C. KIDD,
*Director of Supplies.*

(If bidder is a corporation, Form 1264 must be filled out and attached to the contract.)

### VETERANS' BUREAU FEES

#### *Abdominal surgery*

| | | |
|---|---|---|
| 101 | Esophagoscopy | $42.80 |
| 101a | Esophagoscopy and biopsy or removal of foreign body | 53.50 |
| 102 | Gastroscopy | 42.80 |
| 103 | Liver abscess | 123.00 |
| 104 | Abdominal fixation for prolapse of rectum | 123.00 |
| 105 | Anastomosis, intestinal | 128.40 |
| 106 | Anastomosis, ureterointestinal: | |
| | One-stage | 107.00 |
| | Two-stage | 160.50 |
| 107 | Appendectomy | 80.25 |
| 108 | Cardiospasm, dilatation for | 32.10 |
| 109 | Cholecystectomy | 149.80 |
| 110 | Cholecystotomy | 107.00 |
| 111 | Choledochotomy | 149.80 |
| 112 | Colostomy | 80.25 |
| 113 | Esophagus dilatation, by means of Bougies | 32.10 |
| 114 | Fulguration, tumor—bladder trachea, or esophagus (minor) | 48.15 |
| 115 | Gastrectomy (partial) | 160.50 |
| 116 | Gastroenterostomy | 144.45 |
| 117 | Herniotomy, diaphragmatic | 107.00 |
| 118 | Herniotomy—ventral, inguinal, or femoral: | |
| | Single | 80.25 |
| | Bilateral | 133.75 |
| 119 | Hysterectomy, abdominal or vaginal (including removal of adnexa) | 160.50 |
| 120 | Intestinal obstruction, operation for | 107.00 |
| 121 | Laparotomy, exploratory | 107.00 |

### *Abdominal surgery*—Continued

| | | |
|---|---|---|
| 122 | Laparotomy and drainage, general peritonitis | $107.00 |
| 123 | Litholapaxy | 80.25 |
| 124 | Meckel's diverticulum, excision of | 107.00 |
| 125 | Papilloma of bladder, operation for | 53.50 |
| 126 | Paracentesis of abdomen | 10.70 |
| 127 | Paracentesis of pericardium | 26.75 |
| 129 | Pyelotomy, with removal of calculus | 107.00 |
| 130 | Pyloroplasty | 133.75 |
| 131 | Splenectomy | 144.45 |
| 132 | Tumor, abdominal, removal of | 107.00 |
| 133 | Tumor, gastrointestinal tract, resection | 160.50 |
| 134 | Ulcer, gastric or duodenal, operation for | 133.75 |

### *Amputations*

| | | |
|---|---|---|
| 201 | Upper arm | 74.90 |
| 202 | Forearm | 74.90 |
| 203 | Finger, one | 21.40 |
| 204 | Fingers, each additional | 10.70 |
| 205 | Foot | 69.55 |
| 206 | Hand | 69.55 |
| 207 | Leg | 90.95 |
| 208 | Thigh | 96.30 |
| 209 | Toe | 21.40 |
| 210 | Toe, each additional | 10.70 |

### *Anesthesia*

| | | |
|---|---|---|
| 301 | Anesthesia: | |
| | For the first hour | 10.70 |
| | For each additional hour, or any fraction thereof | 5.35 |

### *Dislocations*

| | | |
|---|---|---|
| 401 | Carpal bone, one | 26.75 |
| 402 | Carpal bone, each additional | 5.35 |
| 403 | Clavicle | 26.75 |
| 404 | Elbow | 26.75 |
| 405 | Finger, one | 5.35 |
| 406 | Fingers, each additional | 5.35 |
| 407 | Hip | 64.20 |
| 408 | Knee | 32.10 |
| 409 | Mandible | 10.70 |
| 410 | Metacarpal bone, one | 16.05 |
| 411 | Metacarpal bones, each additional | 5.35 |
| 412 | Metatarsal bone, one | 16.05 |
| 413 | Metatarsal bones, each additional | 5.35 |
| 415 | Patella | 32.10 |
| 417 | Rib | 10.70 |
| 418 | Shoulder | 32.10 |
| 419 | Shoulder, recurrent or habitual (non-Oper.) | 26.75 |
| 420 | Tarsal bone, one | 26.75 |
| 421 | Tarsal bones, each additional | 5.35 |
| 422 | Thumb | 5.35 |
| 423 | Toe, one | 5.35 |
| 424 | Toes, each additional | 5.35 |
| 425 | Vertebra, one or more | 107.00 |

### *Examinations*

| | | |
|---|---|---|
| 501 | Dermatological examination | 6.40 |
| 502 | Electrocardiogram, with interpretation | 10.70 |
| 503 | Examination of ears, nose, and throat (separately or together) | 5.35 |
| 504 | Special ear examination, including audiometric test with chart | 10.70 |
| 505 | Special ear examination, to include either caloric or Barany test or both, with report | 10.70 |
| 506 | Examination of eyes (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy) | 10.70 |

### *Examinations*—Continued

| | | |
|---|---|---|
| 507 | Examination of eyes with refraction, of mydriatic is used (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy) | $13. 40 |
| 508 | Combined examination of eyes, ears, nose, and throat with refraction (with or without mydriatic) | 16. 05 |
| 509 | Genitourinary examination without cystoscopy | 5. 35 |
| 510 | Gynecological examination | 5. 35 |
| 511 | Complete examination of heart, including electrocardiography | 16. 05 |
| 512 | Physical examination of heart or lungs | 5. 35 |
| 513 | Neurological examination | 16. 05 |
| 514 | Neuropsychiatric examination | 16. 05 |
| 515 | Routine office examination, including treatment | 3. 20 |
| 516 | Orthopedic examination | 5. 35 |
| 517 | Physical examination to determine need for hospitalization | 3. 20 |
| 518 | General routine physical examination | 5. 35 |
| 519 | Proctoscopy or sigmoidescopy | 5. 35 |
| 520 | General surgical examination | 5. 35 |
| 521 | Ventriculography, air injection through skull for diagnostic purposes (not including x-ray) | 42. 80 |

### *Compound fractures*

| | | |
|---|---|---|
| 601 | Carpal bone, one | 48. 15 |
| 602 | Carpal bones, each additional | 16. 05 |
| 603 | Clavicle | 42. 80 |
| 604 | Coccyx | 53. 50 |
| 605 | Femur | 133. 75 |
| 606 | Femur, when suture, plating, or nailing | 160. 50 |
| 607 | Fibula | 42. 80 |
| 608 | Fibula, suture or plating | 80. 25 |
| 609 | Finger, one | 21. 40 |
| 610 | Fingers, each additional | 10. 70 |
| 611 | Humerus | 80. 25 |
| 612 | Humerus, suture or plating | 133. 75 |
| 613 | Malar bone | 53. 50 |
| 614 | Mandible (wiring if necessary) | 85. 60 |
| 615 | Metacarpal bone, one | 26. 75 |
| 616 | Metacarpal bone, each additional | 10. 70 |
| 617 | Metatarsal bone, one | 26. 75 |
| 618 | Metatarsal bones, each additional | 10. 70 |
| 619 | Nasal bones | 26. 75 |
| 620 | Patella | 53. 50 |
| 621 | Patella, suture or plating | 107. 00 |
| 622 | Pelvis | 85. 60 |
| 623 | Pelvis, suture or plating | 160. 50 |
| 624 | Radius or ulna, or both | 58. 85 |
| 625 | Radius or ulna, or both, suture or plating | 133. 75 |
| 626 | Rib, one | 16. 05 |
| 627 | Ribs, each additional | 5. 35 |
| 628 | Sacrum | 64. 20 |
| 629 | Scapula | 48. 15 |
| 630 | Skull vault | 107. 00 |
| 631 | Sternum | 64. 20 |
| 632 | Tarsal bone, one | 48. 15 |
| 633 | Tarsal bones, each additional | 16. 05 |
| 634 | Tibia | 64. 20 |
| 635 | Tibia, suture or plating | 107. 00 |
| 636 | Tibia and fibula | 80. 25 |
| 637 | Tibia and fibula, suture or plating | 133. 75 |
| 638 | Toe, one | 21. 40 |
| 639 | Toes, each additional | 10. 70 |
| 640 | Vertebra, one or more | 133. 75 |

### *Simple fractures*

| | | |
|---|---|---|
| 701 | Carpal bone, one | 32. 10 |
| 702 | Carpal bone, each additional | 5. 35 |

### *Simple fractures*—Continued

| | | |
|---|---|---|
| 703 | Clacivle | $26.75 |
| 704 | Coccyx | 16.05 |
| 705 | Femur | 90.95 |
| 706 | Femur, suture or plating | 133.75 |
| 707 | Tibia or fibula, including Pott's fracture | 53.50 |
| 708 | Tibia or fibula, including Pott's fracture, suture or plating | 133.75 |
| 709 | Finger, one | 10.70 |
| 710 | Fingers, each additional | 5.35 |
| 711 | Humerus | 53.50 |
| 712 | Humerus, suture or plating | 107.00 |
| 713 | Malar bone | 21.40 |
| 714 | Mandible (wiring if necessary) | 80.25 |
| 715 | Maxilla, superior (wiring if necessary) | 80.25 |
| 716 | Metacarpal bone, one | 16.05 |
| 717 | Metacarpal bones, each additional | 5.35 |
| 718 | Metatarsal bone, one | 16.05 |
| | Metatarsal bones, each additional | 5.35 |
| 719 | Nasal bones | 16.05 |
| 720 | Patella | 26.75 |
| 721 | Patella, suture or plating | 80.25 |
| 722 | Pelvis | 53.50 |
| 723 | Pelvis, suture or plating | 133.75 |
| 724 | Radius or ulna, including Colles's fracture | 37.45 |
| 725 | Radius or ulna, including Colles's fracture, sature or plating | 107.00 |
| 726 | Rib, one or more | 10.70 |
| 728 | Sacrum | 26.75 |
| 729 | Scapula | 26.75 |
| 730 | Skull | 26.75 |
| 731 | Sternum | 26.75 |
| 732 | Tarsal bone, one | 16.05 |
| 733 | Tarsal bones, each additional | 5.35 |
| 734 | Toe, one | 10.70 |
| 735 | Toes, each additional | 5.35 |
| 736 | Vertebra, one or more | 53.50 |
| 737 | Vertebra, transverse process only | 10.70 |

### *General surgery*

| | | |
|---|---|---|
| 801 | Adenectomy, cervical, inguinal (minor) | 10.70 |
| 802 | Adenectomy, cervical, inguinal (radical) | 69.95 |
| 803 | Biopsy | 10.70 |
| 804 | Breast, resection of (simple) | 53.50 |
| 805 | Breast, resection of (radical) | 133.75 |
| 806 | Carbuncle, excision of | 26.75 |
| 807 | Deep abcess (including ischio-rectal) | 42.80 |
| 808 | Superficial abscess | 5.35 |
| 809 | Femoral artery, ligation of | 53.50 |
| 810 | Fulguration of tumor, superficial | 16.05 |
| 811 | Ingrown toenail, excision of | 10.70 |
| 812 | Thyroid artery, ligation of | 80.25 |
| 813 | Thyroidectomy | 133.75 |
| 814 | Tumor or cyst, deep, removal of | 26.75 |
| 815 | Tumor or cyst, superficial, removal of | 10.70 |
| 816 | Varicose veins, injection treatment, each | 3.20 |
| 817 | Varicose veins, one leg, operation for | 42.80 |
| 818 | Varicose veins, both legs, operation for | 64.20 |

### *Joint resections*

| | | |
|---|---|---|
| 901 | Elbow joint, excision of | 107.00 |
| 902 | Hip joint, excision of | 160.50 |
| 903 | Knee joint, excision of | 107.00 |
| 904 | Shoulder joint, excision of | 160.50 |
| 905 | Wrist joint, excision of | 80.25 |

## *Clinical laboratory examinations*

*Bacteriological examinations*

| | | |
|---|---|---|
| 1001 | Cultural examination for fungi | $5.35 |
| 1002 | Microscopic examination for fungi | 2.15 |
| 1003 | Pneumococcus typing | 5.35 |
| 1004 | Pus or exudate (smear) | 1.10 |
| 1005 | Pus or exudate, cultural examination, classification | 5.35 |
| 1006 | T. Pallidum (dark field) | 5.35 |
| 1007 | Throat culture, classification of organism | 5.35 |
| 1008 | Throat smear | 1.10 |

*Blood*

| | | |
|---|---|---|
| 1009 | Agglutination test for typhoid, paratyphoid, or undulant fever | 2.00 |
| 1010 | Bleeding time | 1.10 |
| 1011 | Blood calcium | 3.20 |
| 1012 | Blood chlorides | 3.20 |
| 1013 | Blood culture, including classification | 5.35 |
| 1014 | Blood platelet count | 1.10 |
| 1015 | Blood smear for malaria | 2.15 |
| 1016 | Blood typing (grouping) | 1.10 |
| 1017 | Carbon dixoxide combining power of blood plasma | 5.35 |
| 1018 | Chemical examination of blood, complete, including creatinin, dextrose, urea, nitrogen (or nonprotein N) and uric acid | 16.05 |
| 1019 | Cholesterol | 3.20 |
| 1020 | Coagulation time | 1.10 |
| 1021 | Complement fixation test--gonococcus infection | 3.20 |
| 1022 | Complement fixation test for syphilis | 3.20 |
| 1023 | Complement fixation test for tuberculosis | 3.20 |
| 1024 | Creatinin | 3.20 |
| 1025 | Dextrose | 3.20 |
| 1026 | Total erythrocyte count | 2.15 |
| 1027 | Fragility test for erythrocytes | 5.35 |
| 1028 | Hemoglobin estimation | 2.15 |
| 1029 | Hydrogen-iron concentration | 5.35 |
| 1030 | Differential leucocyte count | 2.15 |
| 1031 | Total leucocyte count | 2.15 |
| 1032 | Complete blood count, including total counts | 5.35 |
| 1033 | Nonprotein nitrogen | 3.20 |
| 1034 | Occult blood | 1.10 |
| 1035 | Blood phosphorous | 2.15 |
| 1036 | Precipitation test for syphilis | 2.15 |
| 1037 | Reticulocyte count | 2.15 |
| 1038 | Sedimentation rate | 2.15 |
| 1039 | Estimation of sugar tolerance | 10.70 |
| 1040 | Urea nitrogen | 3.20 |
| 1041 | Uric acid | 3.20 |
| 1042 | Van den Bergh blood test for icterus | 2.15 |
| 1043 | Volume index | 3.20 |

*Feces*

| | | |
|---|---|---|
| 1044 | Cultural exam of feces for causative micro-organizm (classification of bacterium) | 8.00 |
| 1045 | Fat in feces | 1.10 |
| 1046 | Parasites and ova | 5.35 |

*Pathological examinations*

| | | |
|---|---|---|
| 1047 | Autopsy, complete with report, including histological examination | 53.50 |
| 1048 | Tissue examination, with report | 5.35 |

*Skin tests*

| | | |
|---|---|---|
| 1049 | Protein sensitization tests (series), including allergens, for purpose of establishing causative factor | 26.75 |
| 1050 | Tuberculin | 3.20 |

*Spinal fluid*

| | | |
|---|---|---|
| 1051 | Examination of spinal fluid for causative organism (smear) | 3.20 |
| 1052 | Cell count | 2.15 |

### *Clinical laboratory examinations*—Continued

*Spinal fluid*—Continued

| | | |
|---|---|---|
| 1053 | Colloidal gold reaction | $5.35 |
| 1054 | Complement fixation test for syphilis | 3.20 |
| 1055 | Cultural exam of spinal fluid, including classification of causative microorganism | 5.35 |
| 1056 | Globulin test | 1.10 |
| 1057 | Complete exam of spinal fluid including complement fixation test, colloidal gold, globulin test, and cell count | 10.70 |
| 1058 | Precipitation test for syphilis | 3.20 |

*Sputum*

| | | |
|---|---|---|
| 1059 | Tubercle bacillus (plain smear) | 3.20 |
| 1060 | Tubercle bacillus (concentration method) | 5.35 |
| 1061 | Exam of duodenal content for pancreatic ferments | 3.20 |
| 1062 | Exam of gastric content for acidity, by histamine | 8.00 |
| 1063 | Exam of gastric content for pepsin | 3.20 |
| 1064 | Routine chemical (including test meal with withdrawal of stomach contents) | 10.70 |

*Urine*

| | | |
|---|---|---|
| 1065 | Chemical examination routine | 1.10 |
| 1066 | Chemical and microscopical examination | 2.15 |
| 1067 | Chlorides | 3.20 |
| 1068 | Creatinin | 3.20 |
| 1069 | Cultural exam, including classification of microorganism | 5.35 |
| 1070 | Hydrogen iron concentration | 1.10 |
| 1071 | Mosenthal test | 2.15 |
| 1072 | Total nitrogen | 3.20 |
| 1073 | Tenal function test (including phenosulphonephthalein) | 3.20 |
| 1074 | Tubercle bacilli | 3.20 |
| 1075 | Urea nitrogen | 3.20 |
| 1076 | Uric acid | 3.20 |
| 1077 | Urobilin | 1.10 |

*Miscellaneous examinations*

| | | |
|---|---|---|
| 1078 | Animal inoculation for diagnosis, with report of autopsy | 10.70 |
| 1079 | Preparation of autogenous vaccine | 10.70 |
| 1080 | Determination of basal metabolic rate | 5.35 |
| 1081 | Hemoglobin esttallquist | 1.07 |

### *Miscellaneous*

| | | |
|---|---|---|
| 1101 | Blood transfusion (administration only, without venesection) | 5.35 |
| 1102 | Nonsurgical drainage of gall bladder | 10.70 |
| 1103 | Electrocardiograms, interpretation of | 5.35 |
| 1104 | Hypodermoclysis | 3.20 |
| 1106 | Injection of alcohol, trigeminal nerve | 26.75 |
| 1107 | Intravenous injection, exclusive of cost of drug | 3.20 |
| 1108 | Application of plaster cast, chest | 16.05 |
| 1109 | Application of plaster cast, thighs and hips | 26.75 |
| 1110 | Application of plaster cast, thigh and leg | 10.70 |
| 1111 | Application of plaster cast, torso | 26.75 |
| 1112 | Application of plater cast, torso and hips | 32.10 |
| 1113 | Application of plaster cast, entire body | 53.50 |

### *Neuro-Surgery*

| | | |
|---|---|---|
| 1201 | Encephalography, air injection by spinal route for diagnostic purposes | 26.75 |
| 1202 | Brain abscess | 160.50 |
| 1203 | Chordotomy | 107.00 |
| 1204 | Gasserian ganglion, excision of | 133.75 |
| 1205 | Laminectomy | 133.75 |
| 1206 | Nerve, suture of | 107.00 |
| 1207 | Supraorbital nerve, injection of | 16.05 |
| 1208 | Neuroma resection of | 53.50 |
| 1209 | Cisterna puncture, including local anesthesia and obtaining fluid | 5.35 |
| 1210 | Lumbar puncture, including local anesthesia and obtaining fluid | 5.35 |
| 1211 | Skull decompression of | 107.00 |
| 1212 | Sympathectomy, cervical lumber and lumbar | 133.75 |

### *Neuro-Surgery*—Continued

| | | |
|---|---|---|
| 1213 | Sympathectomy, periaterial | $107.00 |
| 1214 | Tumor of brain, operation for | 160.50 |

### *Nose and throat*

| | | |
|---|---|---|
| 1301 | Oral abscess (not to include dental or peridental) | 10.70 |
| 1302 | Adenoidectomy | 16.05 |
| 1303 | Antrum, intranasal, drainage of | 16.05 |
| 1304 | Antrum, radical operation for | 85.60 |
| 1305 | Cleft palate, operation for | 107.00 |
| 1306 | Harelip, operation for | 53.50 |
| 1307 | Intubation, laryngeal | 21.70 |
| 1308 | Laryngectomy | 160.50 |
| 1309 | Larynx, cauterization of | 26.75 |
| 1310 | Tumor of larynx, removal of | 53.50 |
| 1311 | Nasal polypus, removal of | 21.40 |
| 1312 | Nasal septum, suomucous resection of | 53.50 |
| 1313 | Pharyngeal abscess, operation for | 16.05 |
| 1314 | Accessory nasal sinuses, irrigation of | 10.70 |
| 1315 | Ethmoid sinus, radical operation for | 80.25 |
| 1316 | Frontal sinus, intranasal, drainage of | 53.50 |
| 1317 | Frontal sinus, radical, operation for | 107.00 |
| 1318 | Sphenoid sinus, drainage of | 53.50 |
| 1319 | Tonsillar abscess, operation for | 10.70 |
| 1320 | Tonsillectomy | 32.10 |
| 1321 | Tonsillectomy and adenoidectomy | 32.10 |
| 1322 | Tracheotomy | 37.45 |
| 1323 | Turbinate bone, galvano-cauterization of | 10.70 |
| 1324 | Turbinectomy | 10.70 |

### *Obstetrics and gynecology*

| | | |
|---|---|---|
| 1401 | Pregnancy, delivery only (all types except Caesarean) | 42.80 |
| 1402 | Miscarriage—to 6 months | 21.40 |
| 1403 | Miscarriage, to 6 months (with D and C) | 32.10 |
| 1404 | Miscarriage, after 6 months | 42.80 |
| 1405 | Caesarean section vaginal or abdominal | 107.00 |
| 1406 | Pregnancy, ectopic (also ruptured) | 133.75 |
| 1407 | Bartholin's gland, incision | 10.70 |
| 1408 | Bartholin's gland, excision | 32.10 |
| 1409 | Urethral caruncle, removal | 16.05 |
| 1410 | Labial tumors and cysts, removal | 26.75 |
| 1411 | Atresia of vagina, correction of | 53.50 |
| 1412 | Perineorrhaphy and rectoceir | 53.50 |
| 1413 | Colporrhaphy, anterior | 32.10 |
| 1414 | Fistula, recto- or vesico-vaginal | 107.00 |
| 1415 | Cul-de-sac, drainage | 32.10 |
| 1416 | Cauterization of cervix | 21.40 |
| 1417 | Dilatation and curettage | 32.40 |
| 1418 | Tubal inflation | 16.05 |
| 1419 | Uterine polypi, removal | 26.75 |
| 1420 | Trachelorrhaphy | 53.50 |
| 1421 | Conization | 21.40 |
| 1422 | Cervix, amputation | 53.50 |
| 1423 | Hysterectomy, vaginal or abdominal | 160.50 |
| 1424 | Myomectomy | 107.00 |
| 1425 | Uterine flexions, etc., correction | 107.00 |
| 1426 | Oophorectomy | 107.00 |
| 1427 | Ovariotomy | 80.25 |
| 1428 | Salpingectomy, with or without oophorectomy or appendectomy | 107.00 |

### *Ophthalmology*

| | | |
|---|---|---|
| 1501 | Cataract, needling operation for | 53.50 |
| 1502 | Cataract, operation for | 107.00 |
| 1503 | Chalazion, operation for | 5.35 |
| 1504 | Corneal ulcer, cauterization of | 5.35 |
| 1505 | Extensive peropheral corneal ulcer, canterization of | 26.75 |

### *Ophthalmology*—Continued

| | | |
|---|---|---|
| 1566 | Ectropion, operation for | $32.10 |
| 1507 | Entropion, operation for | 32.10 |
| 1508 | Enucleation of eye | 80.25 |
| 1509 | Foreign body, removal from conjuctiva (dissection) | 10.70 |
| 1510 | Foreign body, removal from conjunctiva (magnet) | 10.70 |
| 1511 | Foreign body removal from cornea (dissection) | 10.70 |
| 1512 | Foreign body, removal from cornea (magnet) | 16.05 |
| 1513 | Foreign body, removal from eyeball (deep) with or without magnet | 107.00 |
| 1514 | Grattage of lids for trachoma | 10.70 |
| 1515 | Hordeolum, operation for | 5.35 |
| 1516 | Iridectomy | 53.50 |
| 1517 | Lacrymal duct, dilatation of | 5.35 |
| 1518 | Lacrymal sac, excision of | 64.20 |
| 1519 | Pterygium, operation for | 32.10 |
| 1520 | Ptosis, skin and tarsal resection operation | 80.25 |
| 1521 | Strabismus, operation for | 80.25 |

### *Orthopedic*

| | | |
|---|---|---|
| 1601 | Arthroplasty, major joint | 160.50 |
| 1602 | Bone graft (long bone) | 160.50 |
| 1603 | Bone plate, removal of | 37.45 |
| 1604 | Cartilage of condyle of femur, removal of | 80.25 |
| 1605 | Semilunar cartilage, removal from joint | 80.25 |
| 1606 | Clas foot, operation for | 80.25 |
| 1607 | Coccyx, excision of | 53.50 |
| 1608 | Hallux valgus, operation for | 53.50 |
| 1609 | Hallux valgus, bilateral, operation for | 80.25 |
| 1610 | Hammer tow, operation for | 53.50 |
| 1611 | Osteomyelitis, operation for | [1] 53.50 |
| 1612 | Sequestrum, removal of (deep) | [1] 53.50 |
| 1613 | Sequestrum, removal of (superficial) | 16.05 |
| 1614 | Tenorrhaphy, one | 37.45 |
| 1615 | Tenorrhaphy, each additional | 16.05 |
| 1616 | Tenotomy | 37.45 |
| 1617 | Torticollis, operation for | 80.25 |

### *Otology*

| | | |
|---|---|---|
| 1701 | Mastoid, acute, operation for | 107.00 |
| 1702 | Mastoid, radical, operation | 133.75 |
| 1703 | Ossiculectomy | 107.00 |
| 1704 | Paracentesis | 5.35 |
| 1705 | Polypus, removal of | 26.75 |
| 1706 | Lateral sinus, drainage | 133.75 |

### *Proctology*

| | | |
|---|---|---|
| 1801 | Anal fissure, operation for | 26.75 |
| 1802 | Carcinoma of rectum, excision of | 160.50 |
| 1803 | Fecal fistula, abdominal, operation for | 80.25 |
| 1804 | Fistula, rectovaginal, operation for | 107.00 |
| 1805 | Fistula, urethral, operation for | 64.20 |
| 1806 | Fistula, vesico-vaginal, operation for | 107.00 |
| 1807 | Fistula—in-ano, operation for | 53.50 |
| 1808 | Hemorrhoidectomy | 66.90 |
| 1809 | Stricture of rectum, operation for | 74.90 |
| 1810 | Whitehead's operation | 80.25 |

### *Thoracic surgery*

| | | |
|---|---|---|
| 1901 | Bronchoscopy | 42.80 |
| 1902 | Bronchoscopy and biopsy or removal of foreign body | 53.50 |
| 1903 | Thoracoscopy | 53.50 |
| 1904 | Thoracotomy, incision and drainage, including rib resection | 64.00 |
| 1905 | Subphrenic abscess | 128.40 |

[1] And up.

### *Thoracic surgery*—Continued

| | | |
|---|---|---|
| 1906 | Apicolysis | $107.00 |
| 1907 | Lobectomy | 133.75 |
| 1908 | Oleothorax | 53.50 |
| 1909 | Paracentesis of thorax, diagnostic | 5.35 |
| 1910 | Phrenic nerve operation | 32.10 |
| 1911 | Pneumolysis, extra or intrapleural | 107.00 |
| 1912 | Pneumonestomy | 160.50 |
| 1913 | Pneumonotomym cautery | 107.00 |
| 1914 | Pneumoperitoneum, first induction | 16.05 |
| 1915 | Pneumoperitoneum, refills | 10.70 |
| 1916 | Artificial pneumothorax, first induction | 16.05 |
| 1917 | Artificial pneumothorax, refills | 10.70 |
| 1918 | Scalaniotomy | 53.50 |
| 1919 | Thoracotomy, without rib resection | 42.80 |
| 1920 | Thoracoplasty, each stage | 133.75 |

### *Surgical care of traumatic wounds*

| | | |
|---|---|---|
| 2001 | Incised, minor procedure (office type) | 6.40 |
| 2002 | Lacerated | 10.70 |
| 2003 | Punctured | 6.40 |

### *Urology*

| | | |
|---|---|---|
| 2101 | Genito-urinary examination with cystoscopy | 21.40 |
| 2102 | Prostatic abscess, incision and drainage | 53.50 |
| 2103 | Circumcision (infant) | 10.70 |
| | Circumcision (adult) | 16.05 |
| 2104 | Cystotomy, suprapubic | 53.50 |
| 2105 | Epididymectomy | 69.55 |
| 2106 | Hydrocele, aspiration for | 5.35 |
| 2107 | Hydrocele, operation for | 53.50 |
| 2108 | Nephrectomy or nephrotomy | 144.45 |
| 2109 | Nephropexy | 107.00 |
| 2110 | Orchidectomy | 53.50 |
| 2111 | Prostatectomy, perineal | 160.50 |
| 2112 | Prostatectomy, suprapubic (1 or 2 states) | 160.50 |
| 2113 | Prostatic resection transurethral | 107.00 |
| 2114 | Ureteral stone, removal of | 133.75 |
| 2115 | Urethral stricture, dilation of | 5.35 |
| 2116 | Urethrotomy, external | 80.25 |
| 2117 | Urethrotomy, internal | 53.50 |
| 2118 | Varicocele, operation for | 53.50 |

### *Visits*

| | | |
|---|---|---|
| 2201 | Visit to home or hospital (not over 3 miles from office) | 4.30 |
| 2202 | Night visit away from office (not over 3 miles from office) | 6.40 |
| 2203 | Office visit, with treatment | 3.20 |
| 2204 | Visit out of city for examination or treatment (over 3 miles from office) (Visit fee plus 75¢ per mile). | |
| 2205 | Consultation in hospital | 10.70 |
| 2206. | Neuropsychiatric therapy (minimum 50 minutes) | 10.70 |

### *X-ray*

| | | |
|---|---|---|
| 2301 | Abdomen, flat plate | 8.05 |
| 2302 | Ankle joint, anterior-posterior, and lateral views | 8.05 |
| 2303 | Arm, humerns, anterior-posterior and lateral views | 10.70 |
| 2304 | Bladder, with injection, anterior-posterior and lateral views | 16.05 |
| 2305 | Chest, survey film | 5.35 |
| 2306 | Chest for pulmonary, cardiac, or rib fracture diagnosis stereo | 10.70 |
| 2307 | Chest, fluoroscopic | 5.35 |
| 2308 | Colon, by barium enema | 16.05 |
| 2309 | Clavicle, anterior-posterior and lateral views | 8.05 |
| 2310 | Elbow, anterior-posterior and lateral views | 8.05 |
| 2311 | Encephalography | 16.05 |
| 2312 | Encephalography, including preliminary skull | 26.75 |

### *X-ray*—Continued

| | | |
|---|---|---|
| 2313 | Eophagus (only) | $10. 70 |
| 2314 | Finger | 5. 35 |
| 2315 | Fistulae, contrast study | 10. 70–16. 05 |
| 2316 | Foot, anterior-posterior and lateral views | 8. 05 |
| 2317 | Forearm, radius and ulna, anterior-posterior and lateral views | 10. 70 |
| 2318 | Foreign body in eye, location of<br>(Fragment charted in 3 plans and its dimensions ascertained by method of Sweet or equivalent) | 21. 40 |
| 2319 | Gallbladder, Graham technic | 16. 05 |
| 2320 | Gallbladder, G. I., barium enema | 53. 50 |
| 2321 | Gastrointestinal tract, complete X-ray study, including fluoroscopy | 37. 45 |
| 2322 | Gastrointestinal tract by barium meal and enema | 37. 45 |
| 2323 | Hand, anterior-posterior and lateral views | 5. 35 |
| 2324 | Heart, single teleoroentgenogram | 10. 70–16. 05 |
| 2325 | Hip joint, anterior-posterior and lateral views | 10. 70 |
| 2326 | Kidneys, right and left, for comparison | 10. 70 |
| 2327 | Kidney, ureter, and bladder | 10. 70 |
| 2328 | Knee joint, anterior-posterior and lateral views | 8. 05 |
| 2329 | Kymograph (chest or abdomen) | 8. 05 |
| 2330 | Leg, tibia and fibula, anterior-posterior, and lateral views | 10. 70 |
| 2331 | Lipoidal injection for bronchiactases, etc., including roentgen | 26. 75 |
| 2332 | Mammary gland study | 16. 05 |
| 2333 | Mandibles, each | 10. 70 |
| 2334 | Mastoids, regular | 10. 75 |
| 2335 | Mastoids, including petrous pyramids | 10. 70 |
| 2336 | Maxilla and facial bones | 10. 70 |
| 2337 | Myelography | 21. 40 |
| 2338 | Neck, for soft tissue | 10. 70 |
| 2339 | Nose | 10. 70 |
| 2340 | Optic foramina | 16. 05 |
| 2341 | Pelvis, anterior-posterior and lateral views | 10. 70 |
| 2342 | Pregnancy, with measurements | 21. 40 |
| 2343 | Pregnancy, without measurements | 10. 70 |
| 2344 | Pyelography, intravenous | 26. 75 |
| 2345 | Pyelography, retrograde | 16. 05 |
| 2346 | Sella turcica | 10. 70 |
| 2347 | Semilunar cartilage, both knees | 16. 05 |
| 2348 | Shoulder girdle | 10. 70 |
| 2349 | Sialography (without medium) | 10.70 |
| 2350 | Sinuses, paransal | 10. 70 |
| 2351 | Skull | 10. 70 |
| 2352 | Smith-Peterson nail | 26. 75 |
| 2353 | Spine, cervical anterior-posterior and lateral views | 10. 70 |
| 2354 | Spine dorsal | 10. 70 |
| 2355 | Spine, lumbar-sacral, with coccyx | 16. 05 |
| 2356 | Spine, entire | 26. 75 |
| 2357 | Stomach and duodenum only | 16. 05 |
| 2358 | Stomach, duodenum and gallbladder (dye) | 26. 75 |
| 2359 | Teeth, single | 2. 15 |
| 2360 | Teeth, one fourth set | 4. 30 |
| 2361 | Teeth, one-half set | 5. 35 |
| 2362 | Teeth, complete (periapical examination) | 10. 70 |
| 2363 | Thigh, femur, anterior-posterior and lateral views | 10. 70 |
| 2364 | Thorax, ribs | 10. 70 |
| 2365 | Toe | 5. 35 |
| 2366 | Urethro-cystography | 10. 70 |
| 2367 | Uterosalpingography | 32. 10 |
| 2368 | Ventriculography | 16. 05 |
| 2369 | Ventriculography, including preliminary skull | 26. 75 |
| 2370 | Wrist | 8. 05 |

### *Fluoroscopic and general*

| | | |
|---|---|---|
| 2371 | Reduction of fractures | 5. 35 |
| 2372 | Foreign body, detection | 5. 35 |
| 2373 | Foreign bodies in esophagus or respiratory tract | [1] 10. 70 |

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[1] And up.

*Fluoroscopic and general*—Continued

| | | |
|---|---|---|
| 2374 | Portable examination in hospital, add | $5.35 |
| 2375 | Fluoroscopic, chest or abdomen | 5.35 |

*Interpretation of roentgenograms*

| | | |
|---|---|---|
| 2376 | Bones and joints, plain anterior-posterior and lateral | 5.35 |
| 2377 | Chest for pulmonary diagnosis, plain or stereo | 5.35 |
| 2378 | Gastrointestinal series | 5.35 |
| 2379 | Genito-urinary tract | 5.35 |
| 2380 | Kidney films | 5.35 |
| 2381 | Skull, following ventriculography or encephalography | 5.35 |

*Radiation therapy*

| | | |
|---|---|---|
| 2382 | Low voltage superficial radiation therapy, unfiltered: | |
| | Per portal or area treated | 5.35 |
| | Each additional portal or area treated | 3.20 |
| 2383 | Low voltage superficial radiation therapy, filtered: | |
| | Minimum per portal or area | 5.35 |
| | Maximum | 10.70 |
| | Each additional portal or area | 5.35 |
| 2384 | Low voltage hypermassive unfiltered radiation: | |
| | Per treatment, regardless of size of lesion or time element | 26.75 |
| 2385 | Deep therapy, 200 to 400 kilovolts: For the treatment of infections, bursitis, etc., per each area treated | 10.70 |
| 2386 | Deep therapy, 200 to 400 kilovolts: | |
| | For malignancies, such as carcinoma of breast, prostate, uterus, ovary, brain, per each area treated | 26.75 |
| | Maximum for complete series (no more than 4 series per year per patient) | 133.75 |
| 2387 | Radium: Plaque treatment, each area, regardless of size or time | 10.70 |
| 2388 | Gamma radiation: | |
| | Per each 100 milligram hours | 5.35 |
| | Maximum charge | 107.00 |
| 2389 | Hypermassive skin does for malignancy: | |
| | Minimum | 26.75 |
| | Maximum | 53.50 |

Senator SMITH. If there is no further business before the committee at this time the committee will recess until Wednesday, May 28, at 9:30 a. m. As was announced earlier, the hearings will be held on Wednesdays, Thursdays, and Fridays.

(Whereupon, at 12 noon, the committee adjourned until 10 a. m. Wednesday, May 28, 1947.)

# NATIONAL HEALTH PROGRAM

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**WEDNESDAY, MAY 28, 1947**

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met, pursuant to adjournment, at 9:30 a. m. in the committee room in the Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Smith, Donnell, Murray, and Pepper.

Senator Smith. The committee will please come to order. Senator Donnell will be here in a few minutes, but I think we will start the hearing.

Senator Murray. I want to call attention to a matter, Mr. Chairman. Dr. Baehr of the New York Academy of Medicine during his testimony before this committee made the statement that under compulsory health insurance "a larger number of people receive medical service," a statement in which I heartily concur. However, Dr. Baehr went on to state that where compulsory health insurance is in operation "the quality of medical service rendered by the individual physician tends to decline."

I have just received an unsolicited letter from Dr. Albert D. G. Blanc of New Zealand bearing on exactly this point which I would like to submit for the record. You will remember that Dr. Baehr had mentioned New Zealand as a particularly horrible example of what might be expected under compulsory health insurance. Here in part is what a New Zealand physician has to say:

> Our medical program is now in full swing in this country. Like every scheme, especially a new one, it has its draw-backs as well as its advantages, but the advantages so far outweigh its disadvantages that very few people would now suggest its repeal. In any case, it has been officially adopted by the opposition parliamentary party. We have managed to establish a remarkable record for infant deaths during 1946. For many years, we led the world with a figure about 32 per 1,000 births. The figure then dropped to about 28 and now has come down to 25.35.

In other words, gentlemen, in New Zealand with compulsory health insurance, the death rate for infants has been brought down to 25.3 per thousand births. For the United States as a whole, we had a rate of 38.3 deaths in 1945, and our very best State in this respect—that of Senator McGrath, one of the cosponsors of the National Health Insurance Act—was 28.2. New Zealand's 25.3 is better than the best American State.

I believe the mothers of America will be more interested in New Zealand's results under compulsory health insurance than in Dr. Baehr's remarks.

United States and Rhode Island figures from United States Bureau of the Census for 1946: The National Office of Vital Statistics gives a provisional estimate of infant mortality in the United States of 36.1 per 1,000 live births—based on January–November 1946, 47 States. Monthly Vital Statistics Bulletin, January 13, 1947.

That letter, by the way, was just delivered to me. It came by air mail from New Zealand and just arrived the day following Dr. Baehr's testimony. I ask to have it printed in the record in its entirety in connection with these remarks.

Senator SMITH. It will be so entered.

(The letter referred to above is as follows:)

WANAKA, NEW ZEALAND, *May 9, 1947.*

DEAR SENATOR MURRAY: At long last I take up the pen in order to let you see that I have not forgotten a promise made to you that I would let you see my book (Money, Medicine, and the Masses) either in manuscript or book form. At present it is in London in the hands of a former colleague of mine who hopes to place it with either Gollanze or the Oxford University Press. I am awaiting word now. Conditions, however, are so bad in England that it sometimes takes 2 years to get a book on the market. On this point I was so informed by an English author who happened to be staying here a few days ago.

I was sorry to see the drift of the political current last November because it seemed to be (imperfectly as I understand American politics) that your important bill would be left high and dry in the ebb of the political tide and it might be many years again before it will be floated off by the inevitable flow. Is this reading of the political scene correct?

Our medical program is now in full swing in this country. Like every scheme, especially a new one, it has its draw-backs as well as its advantages, but the advantages so far outweigh its disadvantages that very few people would now suggest its repeal. In any case, it has been officially adopted by the opposition parliamentary party. A further extension of the medical scheme has brought free dental benefits into force as from February 1, 1947. These benefits, however, are at present limited to those just leaving school, and are available until the patient is 19 years old. They will, of course, be extended as more dentists are available. As you may know, free dental treatment at school has been available for many years.

We have managed to establish a remarkable record for infant deaths during 1946. For many years we led the world with a figure about 32 (U. S. A.-European figure is about 39). The figure then dropped to about 28, and now has come down to 25.35. No doubt many authorities will regard this as the irreducible minimum. At the same time our birth rate is the highest recorded for 30 years in New Zealand, with a rate of 25.24 per 1,000 of population. The high birth rate, I feel sure, is partly due to the remarkable system of family allowance which has been inaugurated over the last few years.

If my book cannot be printed in England within reasonable time I will send you a typewritten copy of the manuscript.

If there are any details of the New Zealand scheme or any particular aspect you want discussed, please let me know.

Yours sincerely,

ALBERT D. G. BLANC.

Senator SMITH. Thank you, Senator Murray. Now this morning, the first witness is Mr. John H. Hayes, president, American Hospital Association, who will make a statement to the committee.

## STATEMENT OF JOHN H. HAYES, PRESIDENT, ACCOMPANIED BY GEORGE BUGBEE, EXECUTIVE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.

Mr. HAYES. Good morning, gentlemen. We are very grateful for this privilege of appearing before you. May I ask that Mr. George Bugbee, the executive director of the American Hospital Association, be permitted to sit with me?

Senator **Smith**. Yes. Is it Dr. Hayes or Mr. Hayes?

Mr. **Hayes**. Mr. Hayes.

Senator **Smith**. Before you begin, will you be good enough to just give us very briefly a biographical outline of your background?

Mr. **Hayes**. Yes, sir. I am superintendent of the Lenox Hill Hospital, New York City, and president of the American Hospital Association. I have held the position as superintendent of the Lenox Hill Hospital for the past 21 years and am on my twenty-second year. Prior to that I had a great deal of business experience in banking and trade-association work.

Senator **Smith**. You are not a medically trained man yourself, are you?

Mr. **Hayes**. No.

Senator **Smith**. You are just on the business end of the administration of hospitals—the administration end of hospitals?

Mr. **Hayes**. That is right. And, naturally, in 21 years, I have gained considerable medical knowledge but not enough to practice medicine.

Senator **Smith**. Did you say you have been with this same Lenox Hill Hospital all that time?

Mr. **Hayes**. Twenty-one years; yes, sir.

Senator **Smith**. Thank you very much. Proceed with your statement, Mr. Hayes.

Mr. **Hayes**. The American Hospital Association officially supports S. 545, the National Health Act of 1947, and we especially favor those provisions which would assist the States in providing medical and hospital care to persons unable to pay for such care. In this statement, we shall try to tell you why we favor these State programs and why we support this legislation. We shall also refer to specific provisions of the bill, and suggest amendments which, in our opinion, would strengthen the programs and make them more workable.

## THE AMERICAN HOSPITAL ASSOCIATION

It might be well to tell you that the American Hospital Association is a voluntary organization of hospitals which is now nearly 50 years old. Our membership includes more than 3,800 hospitals, as well as the 88 Blue Cross Plans that have done so much to bring hospital care within the reach of the average citizen. In our membership we include about 90 percent of the general hospital beds in the United States.

*Objective viewpoint of hospitals.*—As hospital people, we believe we are in a position to see clearly what the needs of the citizens of this country are as regards medical and hospital care. We serve a cross section of our various communities, and we are in everyday contact with the illnesses and health problems, as well as the social and financial problems, of our neighbors. More and more of the health activities of the community are becoming centered in the hospital. In addition to diagnosis, care, and treatment, much preventive medicine is being practiced in hospitals by physicians who utilize the scientific apparatus, the laboratories, and trained technicians that are included in the modern hospital. The hospital today is an essential part of the civic structure of the community, and we have a unique opportunity to observe the needs of our fellow citizens.

Since we come to you as the representatives of community organizations providing hospital service, we speak to you from the viewpoint of unselfish interest aimed only at more adequate provision of hospital service to the people as a whole. Most general hospitals in the United States are operated by charitable organizations, such as churches and community-sponsored, nonprofit corporations controlled by trustees who are outstanding citizens, or by city, county, State, or Federal governments. In 1946 there were 1,082,000 beds in Government hospitals and 386,000 beds in non-Government hospitals. Admissions to governmental hospitals were 4,600,000, while voluntary nonprofit hospitals admitted approximately 9,200,000 cases, primarily to short-term general hospitals.

*Compulsory schemes opposed.*—Last year I was privileged to appear before this committee and present the views of the American Hospital Association in opposition to the proposal for a system of Federal compulsory health insurance. Since then that statement has been picked up and reprinted in several forms. Apparently many people agreed with our position that a compulsory program is neither necessary nor desirable in this country. We do not believe that such a system could be brought about in this country without the loss of much of the spirit and initiative for progress that have brought American medicine and health services to the forefront of the world today. Admittedly, American medical and hospital care is among the world's finest. The principal criticism is that it does not extend widely enough to care for all citizens. We agree that it needs to be expanded; we do not agree that a radical change in its methods of operation is necessary. We do not agree that the present system should be torn down in favor of a federally controlled compulsory system. It is important that any new program should preserve the values and accomplishments of the voluntary system and the impulses and motives which have brought about those accomplishments.

*Recommendations for providing medical and hospital care to all.*—In 1944 the house of delegates of the American Hospital Association adopted a resolution dealing with the problem of making medical and hospital care more readily available. A copy of the resolution is submitted as an appendix to this statement. In the resolution three main points stand out:

1. Extension of voluntary budgeting for the cost of medical and hospital care.
2. Government aid for public and voluntary hospital construction upon evidence of unmet needs.
3. Local, county, State, and Federal Government aid for the hospital and medical care of the indigent, with emphasis upon local participation.

### VOLUNTARY BUDGETING FOR MEDICAL AND HOSPITAL CARE

The American Hospital Association is proud of the record of the Blue Cross hospital prepayment plans, because the Blue Cross principle has been sponsored and developed as a public service by the hospitals. Eighty plans in the United States now protect more than 25,000,000 persons—almost 1 out of 5 in our population—and this number is growing constantly. Nearly 3,500,000 were enrolled in 1945, and last year's enrollment was nearly 6,000,000. (The precise figures are 3,478,007 and 5,887,219, respectively.) Although Blue Cross plans involve some insurance principles, their chief distinction is that, for the most part, their benefits are paid, not in dollars, but in hospital services, and those services are guaranteed by participating hospitals. The work of Blue Cross is being supplemented by commercial insurance. Physician-sponsored medical prepayment plans are developing rapidly. Public protection offered through these various media is not complete but is directed toward the heavy cost of illness imposed on the individual who requires hospitalization; it should also be borne in mind in evaluating practical contributions by Blue Cross and prepaid medical plans that the injection of payment for small services such as each visit to a physician's office brings major administrative problems which are avoided in present programs with practically no loss of protection to the individuals covered.

The success of Blue Cross plans is an indication that the American people are able and willing to make their own provision for medical and hospital care without the interference of a cumbersome Federal scheme of compulsion controlling not only collection of premiums but the vastly more significant and delicate function of purchasing all medical and hospital services offered as benefits. It is typically American that we should wish to retain as much freedom as possible in the handling of such a purely personal matter as health. The Blue Cross prepayment principle enables the independent, self-sufficient citizen to budget his own expenditures for hospital and medical care. Blue Cross preserves the best values of the voluntary health system which has made such outstanding progress in this Nation.

Since our resolution was adopted in 1944, Blue Cross enrollment has increased 75 percent. It now protects 20 percent of the population, and the increase continues. We believe that our recommendation for extension of such voluntary budgeting has been accepted by a sufficient portion of the population to indicate its value and its potentialities for success.

*Federal pay-roll deductions for prepayment plan protection favored.*—We have already referred to the phenomenal success of the Blue Cross plans in bringing hospital care within the financial reach of the average citizen. We have often deplored the fact that, as the largest employer in the Nation, the Federal Government has denied its employees the opportunity to have pay-roll deductions made for their participation in these plans, although such deduction is one vital feature of the phenomenal growth of Blue Cross. We are pleased to note that a provision has been included in S. 545 which will make it easier for Federal employees to purchase this protection against the emergency cost of illness. There cannot be any objection to allowing Federal employees this privilege which is enjoyed by employees in private industry in every part of the country. We cannot too strongly urge favorable action on this provision.

## GOVERNMENT AID FOR NEEDED HOSPITAL CONSTRUCTION

In recent years hospital construction has lagged. There are many reasons for this: Shortage of money during depression years, present shortage of building materials and labor, the abnormal conditions of war, and the heavy increase in cost of construction. At the same time, demand for hospital care has increased due to the normal increase of population, greater acceptance of the need for hospital care, and the influence of Blue Cross Plans in making hospital care more easily available financially. As a result, there is an acute shortage of hospital facilities in this country; every hospital is crowded and many areas are still without adequate hospital facilities.

Hospitals have usually been built, and must usually be supported, by the communities which they serve. Many rural areas of low income have not been able to afford hospital construction. These areas have also suffered from their inability to organize in establishing a community service such as a hospital as compared with opportunities for similar progress in larger cities.

Recognizing this situation, the American Hospital Association with grants from three charitable foundations, the Kellogg Foundation, the Commonwealth Fund, and the National Foundation for Infantile Paralysis, set up an independent commission on hospital care to study regard to further development of our hospital system. The report of the existing situation, and determine the needs of the country with this commission last October, based on a careful, 2-year study, is having a profound influence upon the country-wide planning of hospital construction.

Meanwhile, the Hill-Burton bill was introduced in the Congress, providing for assistance to every State to survey its own hospital facilities and needs, and to develop plans for extending hospital services into those areas where needs are greatest. Passage of that act (Public Law 725) by the Congress last year, has already stimulated practically every State and Territory to make a survey of its hospital facilities and needs. The program of hospital building is already well along in the planning stage, and there is now assurance that there will be additional hospitals in those areas where our citizens will best be able to use them.

The inadequacy of hospital service in some areas has had a more profound effect than merely depriving those areas of hospital service. Physicians cannot properly practice in areas that are without adequate hospital facilities. They find it discouraging without the use of the technical equipment and trained personnel which a hospital makes available to assist in the treatment of illnesses and injuries. Consequently areas without hospitals have difficulty in obtaining adequate medical care. It is believed that the more adequate distribution of hospital facilities which will be brought about by the Hospital Survey and Construction Act will have a profound effect in stimulating the wider distribution of physicians, dentists and nurses into area of such need. In this connection, there is a provision in the legislation before you which permits subsidies to physicians and dentists to encourage them to establish themselves in areas which could not otherwise afford such services. We approve this subsidy suggestion.

It is worth noting that the Hill-Burton Hospital Survey and Construction Act established a new principle of Government assistance and cooperation with existing voluntary agencies in the health field. Federal aid is made available to voluntary nonprofit organizations as well as to governmental agencies. The American Hospital Association is gratified by this development because cooperation between public and voluntary agencies in the field of health is highly desirable. We observe this principle in S. 545, which is now before you for study. We strongly urge that this principle be developed and expanded at every level of government. Public authorities should be encouraged to make fullest possible use of existing voluntary agencies in programs for the improvement of the health of our citizens.

### GOVERNMENT AID FOR LOW-INCOME GROUPS

After extension of Blue Cross and other prepayment plans, and Government aid for public and voluntary hospital construction, the third step of our recommended program is local, county, State, and Federal Government aid for the care of the indigent, with emphasis on local participation.

We know that the wealthy are financially able to secure adequate medical and hospital service. We know that the Blue Cross and medical prepayment plans bring such service within the reach of the great average middle classes which form the majority of our population and to many of the low-income group who are often assisted in payment of premiums by their employers. But we also know that there will always be a portion of our population which must have some financial assistance in obtaining proper medical and hospital care.

This low-income group has not been entirely neglected. In many areas, it has always been possible for them to obtain hospital service on a charitable basis. In many parts of the country, large endowments and gifts have made it possible for the voluntary hospitals to provide hospital care to large numbers of those unable to pay. In some areas, State and local governments aid in care of the needy by appropriating funds to apply on the cost of hospital care in voluntary hospitals. In other areas government has met, at least partially, its responsibility for care of needy persons by public assistance programs and by building and maintaining its own hospitals.

Oppose separate hospitals for poor: The general result of Government efforts to provide care for low-income groups in governmental hospitals has resulted in the development of two types of hospital services, one of high quality for the average citizen who pays his own bills or who may be the recipient of voluntary charity, and a separate class of publicly owned hospitals providing care for persons of low income at public expense. In the development of programs for providing care to persons of low income, precaution should be taken against the continuance of this trend. It is desirable that all patients be cared for in the same institutions with the same quality of care. Separate hospitals for the care of the poor tend to establish a different quality of care, and in many instances, State, county, and city governments have made a lower quality inevitable by failure to appropriate funds necessary to provide a high quality of care.

Most of our mental institutions, our tuberculosis sanitaria, and homes for the chronically ill and the aged are State or county institutions. Examination of conditions in these institutions today will reveal that most of them are overcrowded, understaffed, and frequently unable to provide more than an inferior grade of custodial care. But custodial care is not enough; we must persist in attempting cure and rehabilitation, and this requires the high type of medical and hospital facilities that are more frequently found in our community general hospitals. There is a strong trend toward providing treatment and care of such cases, either in, or in close conjunction with, the general hospital, and this was one of the recommendations of the Commission on Hospital Care. Undoubtedly, any program providing medical and hospital care to low-income groups will need to include some provision whereby government may make it possible for mental and tuberculosis patients and patients with long-term illnesses to receive care in or near community general hospitals.

Hospitals now provide charity care: Hospitals in every part of the Nation provide a large amount of charitable service. And at this point it should be noted that charity service does not mean free care, for there is no such thing as free care. Hospital care is expensive, and it must be paid for by someone. The hospital must buy its supplies, its food and drugs and dressing, and hire its nurses and laundry workers and engineers in the open market, just as any other institution. For these it must have money, and that money, as a rule, comes from its patients, from philanthropy, and from government. Naturally, the amount of such charitable care which the hospital can furnish will depend upon the amount of funds available to it from these sources.

Hospital practices and basic conceptions in provision of charitable care do not follow a uniform pattern throughout the country but vary in different areas according to local circumstances and historical background. However, the provision of charitable care according to the financial resources of each hospital is pretty universal. A survey in 1945 indicated that the average nonprofit hospital charged its average patient $1 per day less than the actual cost of rendering such care. Excluding the cost of providing or replacing hospital buildings and equipment, the deficits, amounting to many millions of dollars, were entirely made up from charitable funds.

Voluntary hospitals are finding this burden more difficult to bear because of two developing trends. In the first place, charitable funds are no more plentiful today than in the past, and yet inflationary costs of hospital supplies and salaries and operating expenses cut down tremendously on the amount which can be accomplished with the same funds. In addition, the shortage of personnel of all kinds is accentuated by the tendency of federally operated hospitals to draw their personnel away from other hospitals through the larger salaries they offer. In general, the largest and best training schools will be found in the voluntary hospitals; education of nurses, professional workers, medical students, and physicians is largely carried on in voluntary hospitals. The strategically important position of the voluntary hospital in training professional workers must be recognized in any intelligent program for the expansion of hospital and health services in this country.

Federal aid necessary: The possibility of a Federal program to develop and expand the amount of care available to the needy was recognized when the Hill-Burton bill was before the Senate. The committee report on that bill said:

> In recommending this bill the committee recognizes that S. 191 is addressed only to the provisions of physical plant and that it does not directly deal with the maintenance and operation problem, which is a serious one. It is the conclusion of the committee that assistance in the cost of maintenance and operation of hospitals in the neediest areas should be considered in separate legislation, when more information is available from the surveys to be made.

In other words, this committee recognized that a program designed to aid low-income individuals would naturally make considerable funds available to areas of low income which could not, without such assistance, afford the construction and maintenance of hospitals. S. 545 should directly result in making additional health services available in areas which do not now have such service and will also supplement the Hill-Burton Act in making hospital construction possible in areas of greatest need.

Two hundred million dollars of Federal funds matched with additional State funds could make a substantial improvement in the availability of medical and hospital service to persons of low income. The significance of this sum will be better understood when it is considered that there is now approximately $600,000,000 (an average of $4.76 per capita) being spent by State and local governments each year for this purpose. We have set forth these figures in the appendix to this statement.

Emphasis on local participation: S. 545 proposes a Federal program which aims, among other things, to bring medical and hospital care within reach of persons with low income who could not otherwise afford to pay for it. We support this as a Federal program, but we urge that full importance be given to placing proper emphasis on local participation in the program, in each State, as is permitted in S. 545.

In a carefully devised program, it should be possible to strike a balance which would permit the values of uniformity and individuality to contribute equally to an effective plan. But the balance between these values must be carefully weighed, and care must be taken to preserve the best features of each in a practical manner.

On one hand, it must be remembered that individual freedom and local initiative have been the very cornerstones of our Nation. We have been strong as a Nation, not because of the strength of our Central Government, but because there has been strength, initiative, courage, and freedom in every community in every corner of our great country. Whatever we do for our individual citizens must be done in such a way that this initiative and strength will be preserved. This program somehow must be developed so that each community will feel that it is carrying out the program for itself, and that it is free to carry it out according to its own best judgment. A maximum of responsibility by local government will bring a maximum of self-reliance and effectiveness in the program. We must avoid the illusion that this is a hand-out from the Federal Government which comes to local communities without cost.

In these grants-in-aid programs, it will always be necessary to be vigilant in the preservation of States' rights, and avoidance of a subservient attitude toward the Federal governmental agency. State freedom and responsibility is an ideal which should have more than mere lip service if its fullest benefits are to be realized. Local ingenuity, properly challenged, will frequently establish and carry out a far more satisfactory and progressive program than could possibly be conceived by even the most experienced Federal experts under a federally controlled program. It is the very nature of the American system that local participation in public affairs has resulted in a culture and an economy of unparalleled resiliency and strength.

Mr. David Lilienthal, chairman of the Atomic Energy Commission, in the May 1947 issue of the Reader's Digest has made this point with great clarity, and I quote his first paragraphs:

> Experts in administration are trying to persuade the American people that centralized big government is inevitable. We are told that, because of the complexities of modern living, swift communication and transportation, virtually every problem has become a national problem and that therefore every phase of our lives must be administered from Washington.
>
> It is obvious many problems that once could be dealt with as a matter of local or State policy now do require a national policy. The Central Government, in such cases, through congressional action, must enunciate such a national policy and authorize the expenditure of Federal funds.
>
> But it does not follow that the administration of that policy must be on a Nation-wide basis. We must rid ourselves of the notion that a new staff, with every member paid out of the Federal Treasury, has to administer every detail of each new Federal law or regulation.
>
> The alternative to big government is administration of national policies by State and local units of government. Our problem is to divorce the two ideas of authority and administration of authority. The distinction is one that the apologists for big government persistently overlook.

We favor those provisions of S. 545 which allot a maximum of responsibility and freedom to local governments and communities in devising their own methods of carrying out programs to extend medical and hospital care to low-income groups.

### MEANS TEST

There has been some criticism of the "means test," which is said to be an undesirable feature of this program. The fact that such criticism is not objective is borne out by the widespread, successful use of the means test in the past and at the present time. The means test is nothing more than a simple process for determining whether an individual is financially able to meet the cost of necessary care, and for insuring that aid will reach the individual in need.

Every person who files an income-tax return undergoes a means test. He sets forth in his income-tax return his financial ability to meet a part of the cost of government. Those who cannot afford to pay an income tax receive the services of Government without cost. The American people believe in this basic principle of payment according to financial ability.

Doctors and hospitals apply means tests every day in determining whether needy patients shall receive medical or hospital care without charge, or at partial cost. Community chest contributions, gifts, and charitable endowments for hospital care run into huge amounts every year. These charitable funds are intended for the care of persons whose low income makes it impossible for them to meet the cost of medical and hospital care. Hospitals have been quietly using various sorts of means tests to determine which of their patients are most in need of such financial assistance. There is no reason in these cases for any outrage of personal feelings. The practice is accepted as a fine expression of charitable purpose applied in worthy manner.

Means tests are used in one way or another in many governmental programs such as pensions for widows, for mothers, for the aged, care at State expense for the mentally ill and for the chronically ill. All of these are situations where the State comes to the aid of its citizens who are financially unable to meet the burdens they face. There need be no humiliation involved. But the American sense of justice and fairness cries out in protest against the idea of furnishing such assistance free to individuals who are well able to provide for their own care.

Critics of the means test generally advocate a compulsory health insurance system entirely controlled by government. This, they say, would make medical and hospital care equally available to those who can pay and those who cannot. But would not a means test be necessary, to determine which of our people should contribute, through pay roll taxes or otherwise, to the expense of a vast, Federal health administration? Under such a system, those unable to contribute would be cared for at Government expense, from general tax revenues, and the majority of our citizens, independent and self-reliant, would be taxed for care which they can better afford to buy for themselves. The necessary separation of these two classes for taxing and accounting purposes, makes a means test inevitable, or implies the loosest type of financing such a program, with the resulting shortage of funds which at best is implicit for many reasons in many proposals thus far offered.

Another emotional argument is that health care should be patterned after education, and made available to all. But health care is much more complex than education; the demands upon health care are much more exacting than upon education. And it does not yet appear conclusively that our educational system is beyond criticism as to quality.

As a matter of fact, those who are familiar with the administration of medical and hospital care contemplate a compulsory health system with much apprehension of deterioration in the quality of service now available. It seems to us that the channeling of an increasing amount of hospital and medical care to low-income groups must utilize those devices which have worked successfully in the past and which are universally accepted today. This legislation aims to provide medical and hospital care for those of our citizens who cannot pay for such care. The means test need be nothing more or less than the simple determination of the fact that an individual honestly needs assistance.

### SPECIFIC RECOMMENDATIONS

Thus far, our statement has discussed the general principles which have been or should be followed in a program for making medical and hospital care available to low-income groups. There are numerous features of S. 545 on which we would like to comment specifically.

*National health agency favored.*—The proposal to establish a national health agency seems to us to be worth examination. It has long been believed that the health functions of the Federal Government are of sufficient importance to justify their separation into a unit which would be guided by persons whose primary interest, training and experience are in health work. We believe that the significant sections of this proposed legislation deal with Federal aid to the States granted on the basis of a survey of need in order that medical, hospital, and dental care may be more readily available to low-income groups. The American Hospital Association has made no study of the reorganization of Federal administration contemplated in this act and therefore I have no authority to express any official position.

It is our hope that this issue may be settled without delaying favorable consideration of primary features of the bill.

*Mandatory designation of State health agencies questioned.*—The recommendation that the State agency for administering this plan should be the State health agency may be controversial. We believe that your committee should take notice of the fact that this will not be practical or advisable in every State. For example, several of the States have strong and active welfare departments which might handle such a program. This is a situation where we believe the Federal Government shold be very cautious about the imposition of an arbitrary pattern of administration upon the State. For this reason, we recommend that on page 17, line 10, the words "providing that on or before 1949 such agency shall be the State health agency" should be eliminated. As a matter of fact, the majority of the States will name their State health agencies, anyway.

*Surveys are desirable.*—We favor the proposal to require that State programs be based upon surveys of existing circumstances and needs. Under the hospital survey and construction program, much useful information is being developed by the hospital surveys that have been under way in every State. It is expected that this information will be of great value in determining the scope of that program. A survey of the needs of persons with low income in this country would be of equal value. The fact is that our information regarding the amount of charitable care needed or given is sparse and poorly organized. The present picture is variable from State to State, and from community to community. Before an intelligent program can be developed to meet existing needs, it will be sensible to carry out these surveys to determine what is needed.

*Catastrophic illness requires emphasis.*—We believe that some provision might well be made in this legislation which would provide priority of assistance to cases of catastrophic illness. Indeed, this would seem to be one of the areas of greatest need.

The average citizen is able to pay for minor health services. The primary need for assistance from Government is the case where medical and hospital care becomes suddenly necessary in an amount far beyond the capacity of the individual to pay. A major operation or a long-term illness may put a family in debt for years and may affect the entire future of the members of that family. Such catastrophic illnesses might well be the principal point of attack in this program.

Such cases should be judged at the time they occur, and all of the facts should be taken into consideration at that time. What might be merely an expensive illness for one family might be utterly catastrophic for another family of lower income. Thus, the assistance should be related to the nature of the illness, its duration, cost, and other factors, as well as to the income of the persons involved. We believe that this aspect of the situation deserves thoughtful consideration and study by your committee, and we recommend the insertion of the following sentence in section 712 (a) (4), beginning on page 18, line 24, "Such program must give special consideration to the need for providing assistance for families or individuals in cases of catastrophic illness or injury."

*Variable allotment of funds desirable.*—S. 545 sets up a formula for allotting Federal funds to the States in such a way that those States with less income per capita will receive a greater proportion of Federal assistance. This appears to be sound because of the widely varying ability of the States to meet this problem, and because of the greater need for this program in the States with lower per capita income. It has been shown that the general health of persons in these low-income States is not so good as in the wealthier States. If these lower-income States are to be brought closer to a level with the rest of the country medically, it is plain that special attention must be given to them. This is quite in keeping with the general principle of applying the greatest effort at those points where the need is greatest.

On the other hand, it will be noted that the bill requires State aid equal to that provided by the Federal Government. There is nothing to prevent wealthier States from going far beyond the minimal program; some of them already have excellent programs. But there may be some question as to the ability of the poorer States to match Federal funds with equal amounts of State money for the care of their needy. Where some of the wealthier States might well be financially able to carry a large proportion of the cost of such a program, particularly in view of the smaller proportion of their citizens who would require such assistance, other States, having smaller financial resources and a greater proportion of their population in the low-income category, might need a higher proportion of Federal assistance to develop a satisfactory program. Present expenditures by State and local governments for medical and hospital care for low-income groups is not readily available. We have endeavored to compile such information as is available which will be found in the appendix. It will be noted that apparently non-Federal governments are now spending somewhere in excess of $600,000,000 for this purpose or on a per capita basis $4.76.

Examination of the submitted tables with this report will show that the Federal authorization for appropriation of $200,000,000, if distributed to the States on the formula prescribed in this legislation, would increase present estimated expenditures by as little as 13.8 percent in Montana and by as much as 108.4 percent in Kentucky. The suggested formula for the distribution of funds needs careful examination by your committee. While it seems wise that the Federal allotment should encourage as broad an assumption of responsibility as possible by the State, it would be unfortunate if the degree of participation required of the less-favored States is such as to prevent their utilization of the Federal funds.

*State effort should not be reduced.*—On page 19, line 17, we note that "the financial contribution to be made by the State and its governmental subdivisions shall be at least equal to the amount contributed for similar purposes in the year 1946." This would appear to allow the State to carry on its existing work and to allow the Federal Government to meet the entire expense of anything added.

It would seem that the States should be required to share equally in the cost and responsibility of this program in addition to their present programs. The committee will wish to study this point carefully.

*National medical care council favored.*—The American Hospital Association is pleased to see that there is provision for a National Medical Care Council to work with the Federal agency in developing the over-all policies of this program. Such Council was provided under the Hill-Burton Act, and it has been our observation that the Federal Hospital Council advising with the Federal administrative official and approving his regulations has added much to the effectiveness of that program. It should be noted that the Federal Hospital Council was given joint responsibility with the administrative official who is the Surgeon General of the United States Public Health Service, as well as a semijudicial authority with regard to approval of State plans. Such powers, which have done much to make the hospital-construction program effective and acceptable, do not appear in the present measure. We therefore suggest that section 715 (a) on page 24 should be amended to read:

> Sec. 715 (a). The Director, with the approval of the National Medical Care Council, shall make such administrative regulations as may be necessary to carry out this title.

*Council membership should include hospital representatives.*—It should also be noted that while this is a medical- and hospital-care program, insufficient emphasis has been placed on the part which hospitalization will play in the program. We believe that the National Medical Care Council should include at least two persons familiar with the administration and operation of hospital facilities, and outstanding in the field of hospital administration. Such authorities from the hospital field can render a valuable contribution to the development of a program to extend hospital and medical care to persons of low income, and without such advice serious errors might easily occur. In order to assure this program the benefit of such administration experience, the following amendment should be made in the sentences which begin on page 24, line 22:

> Six of the appointed members shall be persons who are outstanding in the fields pertaining to medical and hospital care, three of whom shall be doctors of medicine, and the other three shall be persons experienced in hospital administration. The other two appointive members shall be persons familiar with the needs for medical and hospital care in urban or rural areas.

*State medical care councils should have authority.*—Under the Hill-Burton Act, many of the States wished to set up advisory councils which would have similar authority to that given to the Federal Hospital Council. We do think it is in keeping with the principle of maximum State freedom that each State should be free to give such authority as it might wish to these councils. It appears, however, that there are those who view this provision with alarm. These persons have urged that the State agencies must be entirely responsible to Federal control. They argue that such Federal control would be jeopardized by allowing these councils to exercise joint authority with the State agency. When this question was raised under the Hill-Burton bill, the Federal Security Agency ruled that the wording of the Federal act expressly prohibited a State advisory council from having more than purely advisory authority. In other words, no authority at all. This appears to be an example of lip service to the principle of States' rights, while, in fact, the States are deprived of the right to establish their own administrative machinery as they may wish. For this reason, we recommend that the word "advisory" be omitted from the description of these councils at the State level and that, "single State agency" be so defined as to allow States to set up such administration as they wish. The State should be free to set up such administrative machinery as they may themselves choose to administer this program.

There are, of course, good reasons for strong and effective councils at both State or Federal levels. The work of the Federal Hospital Council under the Hill-Burton Act has amply demonstrated its value in that program, in spite of the objections of those who warned that it would be dangerous. We believe it is in keeping with the principles of this legislation that the States should be permitted to choose for themselves on this point.

*Payment of Blue Cross premiums favored.*—You have heard the testimony of the representatives of the Blue Cross commission of the American Hospital Association on the proposal to provide medical and hospital care under this program by payment of premiums or partial premiums on behalf of persons of low income to any voluntary nonprofit hospital or medical insurance fund. It should be remembered that one of the factors in the success of the Blue Cross plans has been their nonprofit character which has made it possible for them to render service with very low administrative costs. For this reason, it would probably be wise to limit such premium payments to those organizations which do operate on a nonprofit basis. The bill now does this, and we approve of it.

*Payments to hospitals should approximate cost of service rendered.*—We are pleased to note the provision that arrangements shall be made for payment to institutions for care rendered under this program. We believe we can make a helpful contribution on this point.

The question of purchase of hospital services by agencies of Government has long been a sore point with both hospitals and Government. The difficulty goes back to the early practice of having hospitals bid for the privilege of rendering such services just as in the case of other contractors to supply Government. The practice led to situations where Government agencies undertook to establish arbitrary rates for the purchase of hospital services. Since these rates were often below the actual cost of rendering such services, the hardship upon the hospital was severe.

Obviously, nonprofit hospitals have no desire to make a profit from tax funds. Perhaps they are the only group which has this attitude. However, present funds for care of those unable to pay for hospital services limit the use of hospitals by these groups. After much study by committees of our association, working closely with representatives of Government at every step, a method has been worked out whereby each hospital may calculate its actual cost of rendering hospital services in average cases. This formula was first used in connection with the emergency maternal- and infant-care program with the Children's Bureau. It was picked up for use by other agencies, and the latest to utilize it has been the Veterans' Administration in contracting for care of male veterans with service-connected disabilities and for care of female veterans. These two classes of veterans are permitted by law to be hospitalized in non-Federal hospitals under contract. The experience of hospitals and governments alike in the use of this formula has in general been satisfactory. We are, therefore, suggesting the following amendment which would enable the use of this equitable method of purchasing hospital services under this program: On page 19, line 8, add after the word "individuals": "such payments to be at rates approximating the actual cost of rendering such service."

*Federal responsibility for needy veterans.*—S. 545 contains a provision that nothing in it shall modify obligations assumed by the Federal Government under other statutes for the medical and hospital care of veterans. There can be no disagreement with the principle that the Federal Government should provide in every possible way for the veteran with a service-connected disability. But the question has arisen as to the ability of the Federal Government to care for cases which have no service connection. Congress has authorized hospitalization of non-service-connected cases in Veterans' Administration hospitals only, subject to (1) the availability of vacant beds, and (2) the financial inability of the veteran to pay for his own hospitalization. This authorization was initiated in 1924, withdrawn during the depression in 1933, but reactivated in 1934. Since then 65 to 90 percent of the beds in veterans' hospitals have been occupied by veterans whose disabilities had no connection with their war service. Originally when this authorization was granted the total number of veterans was approximately 4,000,000. Hospital construction costs were lower, and the cost of maintenance was a fraction of what it is now. Today there are 20,000,000 veterans, and both hospital construction costs and per diem maintenance costs have increased 100 percent. The Veterans' Administration now provides 114,000 beds. The current veterans' hospital-building program, as publicized, would provide 150,000 beds by 1950 and about 300,000 beds by 1975.

Experience shows that the largest percentage of these beds will be used for care of non-service-connected cases, and that most of this new construction would not be necessary except to provide hospital care for cases with no war-service connection.

The building of a Federal hospital system of mammoth proportions contemplates the segregation of a substantial group of our population for receiving its hospital care in federally operated hospitals. We believe that this is wrong. Veterans should have the same opportunity as other members of the community to receive hospital care, if they so desire, in their local community hospitals where their neighbors and families receive care.

We very strongly feel that S. 545 should provide means of caring for the needy veteran in non-Federal as well as in Federal hospitals, at public expense.

We believe that the Federal Government could provide better care to the needy veteran in his own community hospital at less expense than by the expenditure of countless millions of dollars for construction of a huge Federal system of special hospitals where the difficulties of providing adequate and efficient hospital service are tremendous as well as expensive.

Therefore, we recommend a specific amendment which would be inserted on page 19, line 21 following the word "title":

> Except in the case of care provided to veterans who shall otherwise qualify for assistance under this section, in which case the Federal aid shall be 100 percent of the cost of such care: *Provided*, That nothing herein shall modify obligations assumed by the Federal Government under statutes for the medical and hospital care of veterans.

In connection with the principles discussed in the above, attention is directed to a quotation from the interim report of the Subcommittee on Wartime Health and Education to the Commitee on Education and Labor. On page 9 of the Subcommittee Report No. 4, appears this paragraph:

> All veterans among the 13,000,000 or more who will not have injuries sustained in the service should be able to obtain adequate medical care for themselves and for their families in their communities. The Veterans' Administration will not be able to assure such care for all in its own facilities even though its plans for ultimate expansion to 300,000 beds are consummated. The problem must be dealt with as part of the larger problem of assuring adequate medical care in every community.

In this we concur as above outlined. A more comprehensive study of this problem prepared by the American Hospital Association is an appendix to this statement.

*Certain categories should have priority.*—S. 545 provides that the State plans should indicate which parts of their program should have priorities, so that the more urgent needs might be taken care of first. In this connection, we suggest that certain priorities might well be specifically suggested in the bill, and accordingly we offer the following amendment to this section:

> In establishing priorities, consideration shall be given to the special needs of the aged, the blind, and children under 18 years of age.

*Dental care programs favored.*—The deficit in dental care is well known. There is apparently little being done on the State level to remedy this situation. The provision of dental examinations for school children, and some financial assistance in making dental care available to persons unable to pay for it, seems wise and we trust that it will have your favorable consideration.

*Periodic examination of school children favored.*—In connection with dental examinations of school children, we wish to point out the fact that periodic physical examinations of school children are also provided in the section which establishes medical and hospital assistance. Undoubtedly, the school age offers major opportunities for early diagnosis of deficiency illnesses and preventive work which can cut down the expense of care and treatment in later years. We also favor this provision.

### SUMMARY OF PRINCIPLES

Thus, the basic recommendations of the American Hospital Association for extending medical and hospital services to all our citizens may be summarized as follows:

1. Extension of voluntary prepayment plans, such as Blue Cross, so that the average citizen may budget his own costs of medical and hospital care. Blue Cross already protects one-fifth of our population, and its phenomenal growth is being matched by the rapid expansion of medical-care plans and other forms of health insurance.

2. Government aid for the construction of additional public and voluntary hospitals in areas where need is shown to be most urgent. The Hospital Survey and Construction Act has already given momentum to such a program.

3. Local, county, State, and Federal aid in providing medical and hospital care to those unable to pay for it, with emphasis on local participation. S. 545, the bill before you for consideration, includes a section which seems to coincide rather well with the recommenda-

tion, and for this reason the American Hospital Association officially supports it.

Certain principles suggested by the resolution of 1944 of the house of delegates of the American Hospital Association are worth repeating here:

> The American Hospital Association urges that as a program is developed for the realization of universal availability of hospital care the following factors be borne in mind:
>
> 1. That it be based upon evidence of unmet needs which the changes will fulfill.
> 2. That it be convenient and economical, utilizing to the greatest possible degree existing resources, motives, and organizations.
> 3. That consideration be given to all other factors which affect individual and public health.
> 4. That the program of evolution attack the most pressing problems. The American Hospital Association warns against decisions based upon administrative expediency and, therefore, believes that, as in other forms of human endeavor, continued improvements can and will be made in hospital service for the American people. In all these matters so vitally affecting the well-being of the population great caution should be taken at the time to preserve American tradition and the spirit of individual initiative and enterprise.

We sincerely believe that legislative proposals for Federal compulsory health insurance which have been and are now before this committee will be, in practical effect, a nationalization of these health services. We do not believe this country subscribes to this step in this field or as a pattern for our Government. That is the basic issue before this committee. S. 545 will not satisfy those who believe in the philosophy of nationalization. We recommend S. 545 as an eminently practical program which in itself will cause major improvement in the distribution of medical and hospital care. With the continued expansion of prepayment programs for hospital and medical care and with the development of the Hill-Burton program for construction of additional hospital facilities, S. 545 will go far toward the completion of a well-rounded program for making the present high quality of care more widely available to the American people.

Senator SMITH. Thank you. Before I turn this over for questioning, I am going to ask Senator Donnell if he will chair the meeting. I am a member of the Foreign Relations Committee. We have an important session in just a few minutes and I have to go. I will ask Senator Donnell if he will take the meeting over and take care of the remaining witnesses.

Senator DONNELL. I would like to ask you one or two questions, Mr. Hayes, if you please. In the concluding portion of your statement, you state this:

> We sincerely believe that legislative proposals for Federal compulsory health insurance which have been and are now before this committee will be, in practical effect, a nationalization of these health services. We do not believe this country subscribes to this step in this field or as a pattern for our Government. That is the basic issue before this committee.

There, Mr. Hayes, you express the view that you do not believe that the country subscribes to this step, that is to say, the step of Federal compulsory health insurance, as I understand your statement.

Mr. HAYES. That is correct.

Senator DONNELL. In that connection, as distinguished from what you think the country's views are, I would like to ask the opinion of the American Hospital Association as regards this statement of your mimeographed testimony on page 2, where you say:

> Last year I was privileged to appear before this committee and present the views of the American Hospital Association in opposition to the proposal for a system of Federal compulsory health insurance.

Now the particular portion of this mimeographed statement to which I call your attention, and I assume, having been absent at the earlier part of this hearing, that in line with your policy of expediting the hearing, that you did not read this next portion, I want to ask you whether or not the language which I am about to read to you immediately following the last quoted portion of your statement is a correct statement of your present view and the view of the American Hospital Association: "Since then"'—I interpret that means since last year, when you appeared before the committee—"that statement has been picked up and reprinted in several forms."

Apparently many people agreed with our position that a compulsory program is neither necessary nor desirable in this country. "We," I take it, means the American Hospital Association. Is that correct?

Mr. HAYES. Yes, sir.

Senator DONNELL (reading):

> * * * do not believe that such a system could be brought about in this country without the loss of much of the spirit and initiative for progress that have brought American medicine and health services to the forefront of the world today. Admittedly, American medical and hospital care is among the world's finest. The principal criticism is that it does not extend widely enough to care for all citizens. We agree that it needs to be expanded; we do not agree that a radical change in its methods of operation is necessary. We do not agree that the present system should be torn down in favor of a federally controlled compulsory system.

May I ask you whether or not the language which I have just read, beginning with the words "Since then" and ending with the words "Federally controlled compulsory system," is to be taken as an expression on your part on behalf of the American Hospital Association to be your view and observation?

Mr. HAYES. Yes, sir.

Senator DONNELL. Senator Pepper, do you desire to ask Mr. Hayes some questions?

Senator PEPPER. Yes. Mr. Hayes, the present Hill-Burton bill authorized, I believe, $75,000,000 a year for 5 years for construction of hospitals. Has that amount yet been made available by the Congress for the construction of these hospitals?

Mr. HAYES. I don't believe the entire 75 has been made available for this year.

Senator PEPPER. Do you know whether any portion of that has been made available?

Mr. HAYES. I will ask Mr. Bugbee. I think part of it was, wasn't it?

Mr. BUGBEE. I don't know exactly what happened. The last I knew was there had been some variation in the action by the House and the Senate. There was an allotment but not an appropriation equal to the 75,000,000, on the basis that State plans were somewhat delayed, and there was no definite estimate as to how much would be needed for the first year.

Senator Pepper. When was the bill passed?

Mr. Bugbee. The last I knew, it had not been, sir.

Mr. Hayes. No. The Hill-Burton bill?

Senator Pepper. It was passed last year, wasn't it, at the last session of the Congress?

Mr. Hayes. Yes, sir.

Senator Pepper. I suppose you know that there have been no hospitals built yet under the appropriation provided for.

Mr. Hayes. So far as I know, not with that money.

Senator Pepper. Mr. Hayes, is it your opinion that an appropriation of $75,000,000 a year from the Federal Government for the construction of hospitals would provide all the hospitals the country needs?

Mr. Hayes. That, together with what philanthropy provides and I assume will provide in the future, plus the matching of State funds will go a long way, Senator, in meeting the shortage.

Senator Pepper. I didn't ask you whether it will go a long way. I asked whether it would provide all the hospitals the people of the country would need.

Mr. Hayes. That is a difficult question. Possibly if we were to do that, we would require more millions than we could get hold of right away. No one has ever accurately estimated how much would be required. There are a great many areas that don't require hospitals but require health centers. Part of the Hill-Burton Act intent is to provide health centers.

Senator Pepper. Is there any legislation on the statute books of the United States Government that would provide all the medical centers that might be required and needed by the people of this country?

Mr. Hayes. There never has been. Philanthropy has done a tremendous job during the last century and a half.

Senator Pepper. What I am interested in, Mr. Hayes, is that as a Senator, I would like to vote for the hospitals and the health centers and all the other things necessary to give the best possible medical care to the people of this country. Do you think that legislation now enacted provides the best possible medical care to the people of this country?

Mr. Hayes. Senator, you continually overlook the fact that even if we do get the money appropriated, buildings don't make hospital care. It takes years to provide the help. It takes 13 to 15 years to create a doctor after he leaves high school. It takes 3 years to produce a nurse. Those are the things that are particularly short today—technicians.

Senator Pepper. Well, is there any legislation in the law of the land today that provides the facilities and the means and contains the plans for the provision of all the doctors and nurses and technicians that the health of the people of this country requires?

Mr. Hayes. None that I know of excepting the GI bill of rights, by which a great many young men and women are going to college and nursing schools, but it still wouldn't be enough for quite a while.

Senator Pepper. Do you think the United States Government is doing everything that can be done to provide the maximum amount of medical care and treatment for the people of this country?

Mr. Hayes. I have always felt that that was a State responsibility primarily and secondly the United States Government's responsibility. I feel that some States are doing an excellent job; some are not.

Senator PEPPER. What interests me, Mr. Hayes, is why we aren't all exerting ourselves to the utmost to formulate plans and to appropriate money and to do what else we can to meet what I assume is the most challenging problem the country faces, namely, the lives and the health of its people.

Mr. HAYES. Well, Senator, the Hill-Burton Act was one step; this is another step.

Senator PEPPER. Would you say it was a step or a toddle?

Mr. HAYES. I would say a worth-while step.

Senator PEPPER. You wouldn't mind if I added that, so far, the step hasn't moved yet, has it?

Mr. HAYES. The Hill-Burton bill has. It has created this momentum whereby practically every State in the country has made a survey of its needs. We have never done that much before. That is real progress.

Senator PEPPER. Well, we haven't yet got any hospitals built, nor have we any appropriation, actually, through the Congress.

Mr. HAYES. We haven't called for the money because the use of the money under the act depends upon the surveys and the licensing acts in the States. Now great progress has been made in this direction.

Senator PEPPER. All I was suggesting, Mr. Hayes, is that a little while ago, we had an enemy that attacked us and threatened to kill a great many of our people and destroy a great deal of our property. We mobilized our forces with magnificence and met that attack to save the lives and property and liberties of our people. Now we have this other enemy which is constantly among us, germs that are killing more of our people than that other enemy did and impairing the power of our country with illness and disease, and I can't understand why we make such a paltry and tardy and sometimes a reluctant approach to an even more deadly enemy among us than the enemy from without. Maybe I am impatient. Maybe I am thinking of the people who have died in the last 6 months and the people who are going to die in the next 6 months because we haven't got adequate medical care.

Maybe I am a little impatient because I think the lives and health of those people are invaluable, and I want witnesses to come in here and tell us how many doctors we need and propose a plan to provide scholarships and fellowships for the education of those doctors and to provide funds to aid private institutions in building more medical schools, providing more nurses and more technicians of all sorts and putting the planning capacity of this country to work and the building strength of this Nation to work building hospitals. That looks to me like a very deserving public approach.

Mr. HAYES. But, Senator, aren't you overlooking the tremendous progress made in medical and hospital care, the expansion of the span of life over the years, the infant care, the care of mothers? Don't you think there has been great progress over the last generation, the greatest progress that has ever been made in the history of medicine and of hospitals? You are probably impatient, as you say, but these are things that cannot be done by revolution; they are evolution. This is part of the evolution.

Senator PEPPER. I am calling attention to what we haven't done and what, I think, we can do.

Mr. Hayes. I am delighted to see that our people in Congress are bearing that in mind, but, as I say, it must be by evolution, not revolution.

Senator Pepper. Well, there is no reason why evolution has to be always at a pace below that of a snail.

Mr. Hayes. Well, it isn't.

Senator Pepper. The hospital program hasn't yet got up to the snail's progress. Now, Mr. Hayes, is the Hill-Burton bill going to provide hospitals, do you think, in the areas where the need is the greatest, for example, in the rural areas?

Mr. Hayes. It is based upon the State surveys of need, and following that, it would be.

Senator Pepper. Suppose you have got a rural area somewhere down in, we'll say, one of our Southern States and you build a hospital. Do you think the people in that area will be able to buy the facilities of the hospital and keep it going?

Mr. Hayes. Well, you wouldn't even get doctors out there or nurses if they could not support the hospital. That is what this bill takes care of.

Senator Pepper. You mean this bill would provide the charity for the patients out in that community, that it would pay the doctors to go out there and serve these poor people that couldn't otherwise pay?

Mr. Hayes. It is to pay for the hospital care of the people in those communities, the indigent in those communities.

Senator Pepper. The Hill-Burton bill provides $75,000,000 a year, if we get it, for building hospitals. The Taft bill provides $200,000,000 a year, Federal aid. Do you think that would enable the States to provide for the people in this country to have the medical care that they need?

Mr. Hayes. If it is in addition to what they are spending now. If it is over $600,000,000 a year.

Senator Pepper. I ask, Is it your deliberate judgment that the $200,000,000 provided by the Taft bill, together with the other funds that will be required, will provide for the health and care of the people of this country?

Mr. Hayes. Not completely. We haven't completely covered education and a great many other things we have been working on for over a century.

Senator Pepper. Well, so far as I know, it is possible for at least practically every child in the United States to go to some kind of school.

Mr. Hayes. Well, you get a varying degree of it, as everybody gets a varying degree of medical attention.

Senator Pepper. Would it be possible for everybody in the United States to go to a hospital if the Taft bill should become a law, as it is possible for every school child in this country to go to school?

Mr. Hayes. With the Hill-Burton Act and the construction of more hospital centers and health centers, we will vastly improve the health of our people by these steps.

Senator Pepper. My question was, Mr. Hayes: Will the Taft bill, with the funds that it is required to be put up by the States, provide the health care the people of the United States need?

Mr. Hayes. Entirely?

Senator Pepper. Yes.

Mr. HAYES. It will make an improvement in it. It will add to it. I have asked earlier whether you meant the complete health care, Senator, or not.

Senator PEPPER. I merely want your judgment, Mr. Hayes, as to whether or not the Taft bill, with the funds that it will require the States to put up, will meet the needs of the people of this country with respect to health care?

Mr. HAYES. It will not entirely meet the needs of the people, but it will make a vast improvement.

Senator PEPPER. We all agree on that. Thank you, Mr. Hayes.

Senator DONNELL. Thank you very much, Mr. Hayes. That is all. The next gentleman to appear this morning is my good, personal friend, Father Alphonse M. Schwitalla of St. Louis, representing the Catholic Hospital Association.

(Mr. Hayes submitted the following appendix I and II of his brief, for the record:)

## APPENDIX I

### A STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION IN REGARD TO HOSPITAL CARE

(A resolution adopted by the House of Delegates at Cleveland, Ohio, October 1944.)

The American Hospital Association must continue to promote the best possible hospital care for the American people and to assist in making such care available to all.

Therefore, the American Hospital Association presents the following statement of policy regarding hospital care:

I. Ideals of the American hospital system.
  (*a*) To render the best possible hospital care.
  (*b*) To make hospital care readily available in all areas and to all people.
  (*c*) To improve constantly standards of hospital care.

II. The hospital's responsibility as a community health center.
  (*a*) Care of the sick, provision of the latest diagnostic and therapeutic services.
  (*b*) Education, physicians, nurses, personnel, and public.
  (*c*) Research, medical care and hospital management.
  (*d*) Participation in a program of preventive medicine.

III. Present program of the American Hospital Association.
  (*a*) Preservation of the values of the voluntary hospital system.
  (*b*) Local, county, state, and Federal government aid for the care of the indigent with emphasis on local participation.
  (*c*) Government aid for public and voluntary hospital construction upon evidence of unmet needs.
  (*d*) Extension of voluntary budgeting for the cost of medical and hospital care.
  (*e*) Extension of interhospital coordination and cooperation both urban and rural.

The American Hospital Association realizes that the existing hospital system does not fulfill completely and perfectly the hospital needs of the American people. It urges that every hospital be alert to the needs of its community. It further recommends a careful analysis of existing deficiencies and urges action to meet them progressively.

The American Hospital Association urges that as a program is developed for the realization of universal availability of hospital care the following factors be borne in mind:

1. That it be based upon evidence of unmet needs which the changes will fulfill.
2. That it be convenient and economical, utilizing to the greatest possible degree existing resources, motives, and organizations.

3. That consideration be given to all other factors which affect individual and public health.
4. That the program of evolution attack the most pressing problems.

The American Hospital Association warns against decisions based upon administrative expediency and therefore believes that as in other forms of human endeavor continued improvements can and will be made in hospital service for the American people. In all these matters so vitally affecting the well-being of the population great caution should be taken at the same time to preserve American tradition and the spirit of individual initiative and enterprise.

## Appendix II

It is conservatively estimated that State and local governments of the United States, excluding the District of Columbia and the Territories, expended 623.8 million dollars for hospitals and medical care in 1946. This amounted to $4.76 per capita. It may be taken for granted that practically all this expenditure was used to provide services for the medically indigent. Assuming that the total expenditure in the Nation in 1946 for hospital and medical care services was 4 percent of the national income or approximately 6.6 billion dollars, the costs to State and local governments were not proportionately large. They were less than 10 percent of the total national hospital and medical care expenditures. In this connection, it should be borne in mind that since most mental and tuberculosis hospitals are operated by State or local governments, the expenditures of these units include the bulk of the costs for operating such institutions. Likewise, the burden of the costs of hospital and medical care was not overly heavy when considered in terms of the total expenditures of State and local governments. These health costs amounted to an estimated 6 percent of the total expenditures of all non-Federal governmental units.

That the pattern of expenditures for hospital and medical services by State and local governments varies from State to State is a matter of common knowledge. Estimates of such expenditures, however, are somewhat difficult. Responsibilities and interrelationships of local governmental units differ among the States. Methods of reporting expenditures are diversified not only between States but also among agencies within the States. Recognizing all these difficulties, gross estimates of expenditures for hospital and medical care by State and local governments were made on a State basis. Estimated costs in 1946 ranged from $1.78 per capita in Kentucky to $10.27 in Montana. (See column 2, exhibit A.) The median per capita expenditure was $4.34.

Under the provisions of S. 545, $200,000,000 would be allotted for the fiscal year ending June 30, 1948, and for each of the succeeding 4 years for general health, hospital, and medical services for the medically indigent. Excluding the District of Columbia and the Territories, States are to be allotted 193.4 million dollars. This is $1.48 per capita. On a State basis per capita allotments would range from $1.04 in Connecticut to $1.93 in several States, mostly located in the southern section of the country. (See column 4, exhibit A.) The median allotment would be $1.58.

Combining the estimated expenditures of State and local governments for hospital and medical care in 1946 with the proposed allotments under S. 545, these governmental units would have available 817.2 million dollars annually to meet the costs of health services for the medically indigent, or $6.24 per capita. (See column 6, exhibit A.) This would represent an increase in per capita expenditures of 31.1 percent over the 1946 rate of expenditure. Increases among the States would range from 13.8 percent in Montana to 108.4 percent in Kentucky. (See column 7, exhibit A.)

The estimated per capita amounts which non-Federal governmental units spend for hospital and medical care are closely related to the economic base of the States, as measured by income payments to individuals. In column 1 on exhibit C, the States are arranged in rank order of per capita income payments in 1945, from low to high. Amounts in this column are those of column 1 on exhibit B, expressed as percentages of the national average. Column 2 on exhibit C shows the estimated per capita expenditures for hospital and medical care by States ranked in order of income payments and expressed in similar fashion. Among the 30 States in which income payments were less than the national average, State and local governments in 21 States spent less than the Nation as a whole for hospital and medical services. In 11 of the 18 States in which income payments were greater than the national average, the estimated costs for health services to the medically indigent were also greater than the national average.

Column 3 on exhibit C shows the per capita allotments under S. 545 for States ranked in order of income and expressed as percentages of the national per capita allotment. The 12 States which would receive the highest per capita allotments ranked lowest among all States in income payments per capita in 1945. All of the 30 States ranking below the national average in per capita income payments would receive more than the national average in allotments under S. 545.

Column 4 on exhibit C shows the effect of the combination of estimated expenditures in 1946 with the proposed allotments under S. 545. In this column the States are ranked in order of per capita income payments and the values presented as percentages of the national average. This column shows that even with the proposed allotments, the combined amount available per capita (assuming the same rate as the estimated expenditure) would be less than the national average in 21 of the 30 States which rank lowest for the Nation in income payments per capita.

Federal grants will be allotted to those States which, generally speaking, are in greatest need of additional hospital facilities. (See columns 2–5, exhibits B, and column 1, exhibit C.) Highest allotments per capita will be made to those having the smallest number of non-Federal hospital beds of all types per 1,000 population. Of the 31 States in which Federal allotments per capita will be greater than the average per capita allotment for the entire country, 24 have less than the national average of 8.8 non-Federal hospital beds of all types per 1,000 persons.

### SOURCES OF DATA

*Exhibit A*

Columns 1, 2: Reports of the Bureau of the Census; reports of the Federal security Agency; reports of the United States Public Health Service; American Hospital Association Data.

Columns 3, 4: Allotments for S. 545.

*Exhibit B*

Column 1: Survey of Current Business, August 1946.

Columns 2, 5: American Hospital Association data.

EXHIBIT A.—*Estimated total and per capita State and local government expenditures for hospitals and medical care, 1946; total and per capita Federal allotments to States under S. 545; estimated total and per capita State and local government expenditures for hospitals and medical care, 1946, combined with S. 545 allotments, with percent increase over estimated expenditures in 1946, by States*

| State | Estimated State and local government expenditures for hospitals and medical care, 1946 | | Federal allotments to States under S. 545 | | Estimated State and local government expenditures for hospital and medical care, 1946 combined with S. 545 allotments | | |
|---|---|---|---|---|---|---|---|
| | Total (in millions) (1) | Per capita (2) | Total (in millions) (3) | Per capita (4) | Total (in millions) (5) | Per capita (6) | Percent increase (7) |
| United States | $623.8 | $4.76 | $193.4 | $1.48 | $817.2 | $6.24 | 31.1 |
| Alabama | 6.8 | 2.42 | 5.4 | 1.93 | 12.2 | 4.35 | 79.8 |
| Arizona | 2.0 | 3.17 | 1.1 | 1.76 | 3.1 | 4.93 | 55.5 |
| Arkansas | 3.7 | 2.08 | 3.4 | 1.93 | 7.1 | 4.01 | 92.8 |
| California | 51.6 | 5.85 | 9.5 | 1.07 | 61.1 | 6.92 | 18.3 |
| Colorado | 9.8 | 8.75 | 1.7 | 1.55 | 11.5 | 10.30 | 17.7 |
| Connecticut | 6.5 | 3.64 | 1.9 | 1.04 | 8.4 | 4.68 | 28.6 |
| Delaware | 1.5 | 5.23 | .3 | 1.13 | 1.8 | 6.36 | 21.6 |
| Florida | 8.4 | 3.52 | 4.1 | 1.75 | 12.5 | 5.27 | 49.7 |
| Georgia | 7.1 | 2.22 | 6.2 | 1.93 | 13.3 | 4.15 | 86.9 |
| Idaho | 2.2 | 4.40 | .8 | 1.60 | 3.0 | 6.00 | 36.4 |
| Illinois | 36.5 | 4.73 | 9.5 | 1.23 | 46.0 | 5.96 | 26.0 |
| Indiana | 21.7 | 6.31 | 4.9 | 1.42 | 26.6 | 7.73 | 22.5 |
| Iowa | 16.9 | 7.48 | 3.5 | 1.56 | 20.4 | 9.04 | 20.9 |
| Kansas | 10.8 | 6.21 | 2.7 | 1.54 | 13.5 | 7.75 | 24.8 |

Exhibit A.—*Estimated total and per capita State and local government expenditures for hospitals and medical care, 1946; total and per capita Federal allotments to States under S. 545; estimated total and per capita State and local government expenditures for hospitals and medical care, 1946, combined with S. 545 allotments, with percent increase over estimated expenditures in 1496, by States*—Continued

| State | Estimated State and local government expenditures for hospitals and medical care, 1946 | | Federal allotments to States under S. 545 | | Estimated State and local government expenditures for hospital and medical care, 1946 combined with S. 545 allotments | | |
|---|---|---|---|---|---|---|---|
| | Total (in millions) (1) | Per capita (2) | Total (in millions) (3) | Per capita (4) | Total (in millions) (5) | Per capita (6) | Percent increase (7) |
| Kentucky | $4.6 | $1.78 | $5.0 | $1.93 | $9.6 | $3.71 | $108.4 |
| Louisiana | 10.5 | 4.28 | 4.7 | 1.93 | 15.2 | 6.21 | 45.1 |
| Maine | 2.5 | 3.18 | 1.2 | 1.55 | 3.7 | 4.73 | 48.7 |
| Maryland | 9.8 | 4.61 | 2.7 | 1.27 | 12.5 | 5.88 | 27.5 |
| Massachusetts | 17.6 | 4.21 | 5.2 | 1.24 | 22.8 | 5.45 | 29.5 |
| Michigan | 26.5 | 4.84 | 7.0 | 1.28 | 33.5 | 6.12 | 26.4 |
| Minnesota | 17.9 | 7.17 | 4.1 | 1.65 | 22.0 | 8.82 | 23.0 |
| Mississippi | 8.9 | 4.28 | 4.0 | 1.93 | 12.9 | 6.21 | 45.1 |
| Missouri | 9.7 | 2.73 | 5.8 | 1.62 | 15.5 | 4.35 | 59.3 |
| Montana | 4.7 | 10.27 | .7 | 1.42 | 5.4 | 11.69 | 13.8 |
| Nebraska | 7.1 | 5.92 | 1.9 | 1.59 | 9.0 | 7.51 | 26.9 |
| Nevada | .8 | 5.00 | .2 | 1.13 | 1.0 | 6.13 | 22.6 |
| New Hampshire | 2.4 | 5.30 | .8 | 1.76 | 3.2 | 7.06 | 33.2 |
| New Jersey | 26.6 | 6.33 | 4.9 | 1.16 | 31.5 | 7.49 | 18.3 |
| New Mexico | 1.1 | 2.06 | 1.0 | 1.93 | 2.1 | 3.99 | 93.7 |
| New York | 85.4 | 6.79 | 13.5 | 1.07 | 98.9 | 7.86 | 15.8 |
| North Carolina | 10.8 | 3.08 | 6.8 | 1.93 | 17.6 | 5.01 | 62.7 |
| North Dakota | 3.9 | 7.48 | .8 | 1.60 | 4.7 | 9.08 | 21.4 |
| Ohio | 28.7 | 4.18 | 8.7 | 1.26 | 37.4 | 5.44 | 30.1 |
| Oklahoma | 8.3 | 4.08 | 3.9 | 1.93 | 12.2 | 6.01 | 47.3 |
| Oregon | 6.2 | 5.14 | 1.5 | 1.25 | 7.7 | 6.39 | 24.3 |
| Pennsylvania | 42.3 | 4.60 | 12.8 | 1.39 | 55.1 | 5.99 | 30.2 |
| Rhode Island | 4.8 | 6.33 | .9 | 1.23 | 5.7 | 7.56 | 19.4 |
| South Carolina | 7.6 | 3.99 | 3.7 | 1.93 | 11.3 | 5.92 | 48.4 |
| South Dakota | 3.4 | 6.12 | 1.0 | 1.72 | 4.4 | 7.84 | 28.1 |
| Tennessee | 11.5 | 3.99 | 5.6 | 1.93 | 17.1 | 5.92 | 48.4 |
| Texas | 21.7 | 3.20 | 12.5 | 1.85 | 34.2 | 5.05 | 57.8 |
| Utah | 2.1 | 3.40 | 1.0 | 1.55 | 3.1 | 4.95 | 45.6 |
| Vermont | 1.0 | 3.22 | .5 | 1.68 | 1.5 | 4.90 | 52.2 |
| Virginia | 12.5 | 4.06 | 5.6 | 1.79 | 18.1 | 5.85 | 44.1 |
| Washington | 8.9 | 4.26 | 2.3 | 1.12 | 11.2 | 5.38 | 26.3 |
| West Virginia | 5.2 | 3.02 | 3.3 | 1.93 | 8.5 | 4.95 | 63.9 |
| Wisconsin | 21.7 | 7.35 | 4.4 | 1.49 | 26.1 | 8.84 | 20.3 |
| Wyoming | 1.6 | 6.48 | .4 | 1.53 | 2.0 | 8.01 | 23.6 |

Exhibit B.—*Income payments to individuals in 1945; total non-Federal beds, non-Federal general and special (short-term) beds, non-Federal mental and allied beds, all other non-Federal beds, per 1,000 population for 1946, by States*

| State | Income payments per capita 1945 (1) | Total non-Federal beds, per 1,000 population (2) | Non-Federal general and special beds (short term), per 1,000 population (3) | Non-Federal mental and allied beds per 1,000 population (4) | All other non-Federal beds, per 1,000 population (5) |
|---|---|---|---|---|---|
| United States | $1,150 | 8.8 | 3.4 | 4.4 | 1.0 |
| Alabama | 700 | 4.2 | 1.8 | 2.2 | 0.2 |
| Arizona | 918 | 5.7 | 3.2 | 1.9 | .6 |
| Arkansas | 654 | 5.2 | 1.6 | 2.6 | 1.0 |
| California | 1,480 | 8.1 | 3.5 | 3.5 | 1.1 |
| Colorado | 1,100 | 11.4 | 4.4 | 5.0 | 2.0 |
| Connecticut | 1,449 | 12.3 | 3.3 | 6.7 | 2.3 |
| Delaware | 1,381 | 12.4 | 3.9 | 6.1 | 2.4 |
| Florida | 996 | 5.3 | 2.4 | 2.5 | .4 |
| Georgia | 745 | 5.0 | 1.9 | 2.8 | .3 |
| Idaho | 1,054 | 7.2 | 3.3 | 3.8 | .1 |

**Exhibit B.**—*Income payments to individuals in 1945; total non-Federal beds, non-Federal general and special (short-term) beds, non-Federal mental and allied beds, all other non-Federal beds, per 1,000 population for 1946, by States*—Con.

| State | Income payments per capita 1945<br>(1) | Total non-Federal beds, per 1,000 population<br>(2) | Non-Federal general and special beds (short term), per 1,000 population<br>(3) | Non-Federal mental and allied beds per 1,000 population<br>(4) | All other non-Federal beds, per 1,000 population<br>(5) |
|---|---|---|---|---|---|
| Illinois | $1,360 | 10.8 | 4.0 | 5.7 | 1.1 |
| Indiana | 1,152 | 7.5 | 3.0 | 4.0 | .5 |
| Iowa | 1,109 | 8.6 | 3.5 | 4.8 | .3 |
| Kansas | 1,113 | 8.1 | 3.6 | 4.2 | .3 |
| Kentucky | 735 | 4.9 | 2.1 | 2.4 | .4 |
| Louisiana | 785 | 6.8 | 3.4 | 3.3 | .1 |
| Maine | 1,051 | 7.9 | 3.5 | 3.6 | .8 |
| Maryland | 1,212 | 9.8 | 3.7 | 4.9 | 1.2 |
| Massachusetts | 1,321 | 13.4 | 4.5 | 6.8 | 2.1 |
| Michigan | 1,212 | 9.7 | 3.1 | 5.4 | 1.2 |
| Minnesota | 1,061 | 11.7 | 4.8 | 5.8 | 1.1 |
| Mississippi | 556 | 3.9 | 1.6 | 2.1 | .2 |
| Missouri | 1,063 | 8.8 | 3.5 | 4.6 | .7 |
| Montana | 1,172 | 6.7 | 5.8 | ------------ | .9 |
| Nebraska | 1,117 | 9.0 | 3.7 | 5.0 | .3 |
| Nevada | 1,243 | 6.9 | 4.2 | 2.7 | ------------ |
| New Hampshire | 971 | 12.5 | 5.0 | 7.0 | .5 |
| New Jersey | 1,373 | 10.2 | 3.7 | 5.2 | 1.3 |
| New Mexico | 812 | 4.8 | 2.1 | 2.0 | .7 |
| New York | 1,595 | 14.0 | 4.8 | 7.7. | 1.5 |
| North Carolina | 732 | 5.5 | 2.6 | 2.4 | .5 |
| North Dakota | 1,123 | 11.4 | 4.9 | 5.8 | .7 |
| Ohio | 1,289 | 8.0 | 3.1 | 4.2 | .7 |
| Oklahoma | 889 | 7.3 | 2.4 | 4.5 | .4 |
| Oregon | 1,266 | 6.5 | 3.9 | 2.1 | .5 |
| Pennsylvania | 1,199 | 9.9 | 3.7 | 4.5 | 1.7 |
| Rhode Island | 1,268 | 10.8 | 2.9 | 5.5 | 2.4 |
| South Carolina | 663 | 5.8 | 2.2 | 3.0 | .6 |
| South Dakota | 1,083 | 8.6 | 3.4 | 4.7 | .5 |
| Tennessee | 813 | 5.6 | 2.2 | 2.6 | .8 |
| Texas | 917 | 5.2 | 2.3 | 2.5 | .4 |
| Utah | 1,023 | 6.6 | 3.4 | 1.9 | 1.3 |
| Vermont | 1,023 | 12.2 | 4.4 | 7.4 | .4 |
| Virginia | 903 | 7.0 | 2.8 | 3.7 | .5 |
| Washington | 1,407 | 8.5 | 3.8 | 4.0 | .7 |
| West Virginia | 839 | 6.6 | 3.3 | 2.4 | .9 |
| Wisconsin | 1,161 | 10.6 | 3.9 | 5.9 | .8 |
| Wyoming | 1,096 | 7.6 | 3.1 | 4.3 | .2 |

**Exhibit C.**—*Indices of income payments to individuals, 1945; indices of estimated per capita State and local government expenditures for hospitals and medical care, 1946; indices of per capita Federal allotments to States under S. 545; indices of estimated per capita State and local government expenditures for hospitals and medical care, 1946 combined with S. 545 allotments; indices of total non-Federal hospital beds per 1,000 population, with all indices expressed as percentage of the national average and States arranged in rank order for indices of income payments to individuals, by States*

| State | Income payments per capita, 1945<br>(1) | Estimated State and local Government expenditures for hospitals and medical care, 1946, per capita<br>(2) | Federal allotments to States under S. 545, per capita<br>(3) | Estimated State and local Government expenditures for hospital and medical care, 1946, combined with S. 545 allotments, per capita<br>(4) | Total non-Federal beds, per 1,000 population<br>(5) |
|---|---|---|---|---|---|
| United States | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Mississippi | 48.3 | 89.9 | 130.4 | 99.5 | 44.3 |
| Arkansas | 56.9 | 43.7 | 130.4 | 64.3 | 59.1 |
| South Carolina | 57.7 | 83.8 | 130.4 | 94.9 | 65.9 |
| Alabama | 60.9 | 50.8 | 130.4 | 69.7 | 47.7 |
| North Carolina | 63.7 | 64.7 | 130.4 | 80.3 | 62.5 |

Exhibit C.—*Indices of income payments to individuals, 1945; indices of estimated per capita State and local government expenditures for hospitals and medical care, 1946; indices of per capita Federal allotments to States under S. 545; indices of estimated per capita State and local government expenditures for hospitals and medical care, 1946 combined with S. 545 allotments; indices of total non-Federal hospital beds for 1,000 populatoin, with all indices expressed as percentage of the national average and States arranged in rank order for indices of income payments to individuals, by States*—Continued

| State | Income payments per capita, 1945 (1) | Estimated State and local Government expenditures for hospitals and medical care, 1946, per capita (2) | Federal allotments to States under S. 545, per capita (3) | Estimated State and local Government expenditures for hospital and medical care, 1946, combined with S. 545 allotments, per capita (4) | Total non-Federal beds, per 1,000 population (5) |
|---|---|---|---|---|---|
| Kentucky | 63.9 | 37.4 | 130.4 | 59.5 | 55.7 |
| Georgia | 64.8 | 46.6 | 130.4 | 66.5 | 56.8 |
| Louisiana | 68.3 | 89.9 | 130.4 | 99.5 | 77.3 |
| New Mexico | 70.6 | 43.3 | 130.4 | 63.9 | 54.5 |
| Tennessee | 70.7 | 83.8 | 130.4 | 94.9 | 63.6 |
| West Virginia | 73.0 | 63.4 | 130.4 | 79.3 | 75.0 |
| Oklahoma | 77.3 | 85.7 | 130.4 | 96.3 | 83.0 |
| Virginia | 78.5 | 85.3 | 120.9 | 93.8 | 79.5 |
| Texas | 79.7 | 67.2 | 125.0 | 80.9 | 59.1 |
| Arizona | 79.8 | 66.6 | 118.9 | 79.0 | 64.8 |
| New Hampshire | 84.4 | 111.3 | 118.9 | 113.1 | 142.0 |
| Florida | 86.6 | 73.9 | 118.2 | 84.5 | 60.2 |
| Utah | 89.0 | 71.4 | 104.7 | 79.3 | 75.0 |
| Vermont | 89.0 | 67.6 | 113.5 | 78.5 | 38.6 |
| Maine | 91.4 | 66.8 | 104.7 | 75.8 | 89.8 |
| Idaho | 91.7 | 92.4 | 108.1 | 96.2 | 81.8 |
| Minnesota | 92.3 | 150.6 | 111.5 | 141.3 | 133.0 |
| Missouri | 92.4 | 57.4 | 109.5 | 69.7 | 100.0 |
| South Dakota | 94.2 | 128.6 | 116.2 | 125.6 | 97.7 |
| Wyoming | 95.3 | 136.1 | 103.4 | 128.4 | 86.4 |
| Colorado | 95.7 | 183.8 | 104.7 | 165.1 | 129.5 |
| Iowa | 96.4 | 157.1 | 105.4 | 144.9 | 97.7 |
| Kansas | 96.8 | 1305. | 104.1 | 124.2 | 92.0 |
| Nebraska | 97.1 | 124.4 | 107.4 | 120.4 | 103.4 |
| North Dakota | 97.7 | 157.1 | 108.1 | 145.5 | 129.5 |
| Indiana | 100.2 | 132.6 | 95.9 | 123.9 | 85.2 |
| Wisconsin | 101.0 | 154.4 | 100.7 | 141.7 | 120.5 |
| Montana | 101.9 | 215.8 | 95.9 | 187.3 | 76.1 |
| Pennsylvania | 104.3 | 96.6 | 93.9 | 96.0 | 112.5 |
| Michigan | 105.4 | 101.7 | 86.5 | 98.1 | 110.2 |
| Maryland | 105.4 | 96.8 | 85.8 | 94.2 | 111.4 |
| Nevada | 108.1 | 105.0 | 76.4 | 98.2 | 78.4 |
| Oregon | 110.1 | 108.0 | 84.5 | 102.4 | 73.9 |
| Rhode Island | 110.3 | 133.0 | 83.1 | 121.2 | 122.7 |
| Ohio | 112.1 | 88.2 | 85.1 | 87.2 | 90.9 |
| Massachusetts | 114.9 | 88.4 | 83.8 | 87.3 | 152.3 |
| Illinois | 118.3 | 99.4 | 83.1 | 95.5 | 122.7 |
| New Jersey | 119.4 | 133.0 | 78.4 | 120.0 | 115.9 |
| Delaware | 120.1 | 109.9 | 76.4 | 101.9 | 140.9 |
| Washington | 122.3 | 89.5 | 75.7 | 86.2 | 95.5 |
| Connecticut | 126.0 | 76.5 | 70.3 | 75.0 | 139.8 |
| California | 128.7 | 122.9 | 72.3 | 110.9 | 92.0 |
| New York | 138.7 | 142.6 | 72.3 | 126.0 | 159.1 |

Senator **Pepper**. Mr. Chairman, before the witness begins, I would like to insert at this point in the record an article dated April 1, 1947, appearing in the Washington Star, headed, "Hospitals Bar Many Due to Shortages, Association Reveals."

The first paragraph reads:

> Every day an average of 15,600 patients is turned away from the Nation's general hospitals because of a shortage of beds or nursing personnel, an American Hospital Association spokesman revealed today.

Senator **Donnell**. It will be placed in the record as part of the Senator's request at this point.

(The newspaper article submitted by Senator Pepper is as follows:)

[Star, Washington, D. C., April 1, 1947]

### HOSPITALS BAR MANY DUE TO SHORTAGES, ASSOCIATION REVEALS

Every day an average of 15,600 patients is turned away from the Nation's general hospitals because of a shortage of beds or nursing personnel, an American Hospital Association spokesman revealed today.

George Bugbee, executive director, said a survey just completed by the association showed 32,100 beds had been withdrawn from service because of the current scarcity of nurses and other hospital workers.

Many hospitals now able to maintain their wards at capacity operation will be forced to close some of them if the personnel situation becomes worse, the report disclosed.

To the fact that existing hospital beds cannot be employed fully, Mr. Bugbee added an estimate that an additional 195,000 new beds are needed throughout the country to provide acceptable standards of nursing care.

Institutions in densely populated areas have been hardest hit by personnel shortages, Mr. Bugbee declared. The survey showed 25 percent of the metropolitan hospitals have been forced to withdraw some beds from service, compared with 8 percent in rural communities.

Tuberculosis wards have suffered most from forced curtailment, with 47.7 percent of tuberculosis institutions reporting some of their facilities closed by lack of attendants.

"The hospital, like everyone else," Mr. Bugbee pointed out, "is faced with increased costs, and these increases must result in higher hospital bills."

He urged increased community support to help hospitals maintain high standards of service to the public. This support, he said, must take the form of financial aid and assistance in the recruiting of professional and nonprofessional nurses.

The Metropolitan Health and Hopital Survey last year showed a capacity of 3,843 general hospital beds in the District, compared to an estimated need of 4,970. A Health Department spokesman said there were no official figures on the beds now available.

Senator DONNELL. At this point, I will insert in the record an article in this morning's Washington Post entitled: Federal "Propaganda" Faces House Probe.

### FEDERAL "PROPAGANDA" FACES HOUSE PROBE

Representative Harness announced yesterday an immediate congressional investigation of Government publicity and "propaganda" which he termed illegal activity costing $75,000,000 a year.

The first phase, Harness announced, will open today, dealing with activities of the Public Health Service, Social Security Board, Agricultural Department, and Office of Education "in behalf of a Nationwide program of socialized medicine."

The inquiry will be in charge of a House Expenditures subcommittee of which the Indianan is chairman.

Government propaganda, he said in a statement, "is a device of dictatorship," represents a "flagrant extravagance of public funds" and is an unwholesome and un-American development in our scheme of constitutional government.

"It will be our plan," Harness said, "to root out such illegal activities in the Federal establishment wherever we may find them."

"We are certain," he said, "that a substantial proportion of this huge publicity fund goes into programs designed to influence legislation, often to develop regional pressures against economy measures decreed by Congress in the appropriation bills."

The subcommittee chairman noted that a law provides for the fining and imprisonment of Federal officials convicted of using general appropriations to influence any Member of Congress for or against "any given piece of legislation"

and so on.

(The newspaper article submitted by Senator Donnell is as follows:)

[The Washington Post, Wednesday, May 28, 1947]

### Federal "Propaganda" Faces House Probe

Representative Harness (Republican, Indiana) announced yesterday an immediate congressional investigation of Government publicity and "propaganda" which he termed illegal activity costing $75,000,000 a year.

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"It will be our plan," Harness said, "to root out such illegal activities in the Federal establishment wherever we may find them."

Preliminary checks, he said, have brought out the $75,000,000 annual bill, although "Congress never has authorized the expenditures of public funds for such activities."

"We are certain," he said, "that a substantial proportion of this huge publicity fund goes into programs designed to influence legislation, often to develop regional pressures against economy measures decreed by Congress in the appropriation bills."

The subcommittee chairman noted that a law provides for the fining and imprisonment of Federal officials convicted of using general appropriations to influence any Member of Congress for or against "any given piece of legislation."

In many cases, he said, the subcommittee has learned that propaganda operations are "shielded or disguised in the auditing vouchers by various subterfuges of accounting procedure."

Dr. Joseph W. Mountin, Director of the Public Health Service's Division of State relations, will be the first witness today.

The Health Service, Federal Security Administration and Agriculture Department, Harness said, for 3 years have been advocating compulsory health insurance. Their officials, he said, have been bringing groups together to draw up regional health programs "on the basis of socialized medicine and compulsory Federal insurance sustained by pay roll deductions."

Harness said the subcommittee has a record of a conference in Jamestown, N. Dak., last September directed by officials of the Health Service, Security Administration and Office of Education.

"The avowed purpose of this conference," he said, "was to train participants in ways and means of agitation for socialized medicine; to bring pressure on Congress for a national health program based on compulsory health insurance."

Senator PEPPER. Mr. Chairman, before Father Schwitalla begins, I have a series of newspaper articles on the hospital situation in the country which I would like to have inserted in the record.

Senator DONNELL. Very well.

(The newspaper articles submitted by Senator Pepper are as follows:)

[From the Citizen, Asheville, N. C., September 9, 1946]

### A Desperate Situation

Asheville's hospital facilities have been taxed to a point approaching public emergency. Adequate medical care no longer can be guaranteed even when the life of the patient may be at stake.

The Citizen makes this statement advisedly and without any thought of sensationalism. The facts speak—every day—for themselves. A survey of responsible medical opinion in yesterday's Citizen-Times merely underscores the widespread apprehensions of thoughtful laymen. One physician was quoted as saying: "I find myself shuddering about what would happen if one of my patients should turn up with a ruptured appendix or some other emergency condition where a matter of hours is vital."

At least two such situations have arisen, precisely as feared, in recent days. We know of one case where a prominent young Asheville woman lay stricken for 6 hours while her physician sought frantically for a hospital bed so that he might schedule an operation. Not many days ago a man died in city jail of injuries suffered sometime earlier because there was no room for him—though obviously he was badly injured—in any hospital.

These are not isolated cases but only the most dramatic of several examples which might be offered. Doctors are compelled to take valuable time from their practice and the regular care of patients to wheedle hospital beds in dire emergency. It is unthinkable what might happen if epidemic or disaster struck this community or its dependent neighbors. For instance, there is no isolation ward of any description either for children or for adults in any Asheville institution. The tragic irony of all this is that our physicians have been telling us for months, even years, that the community one day would confront a medical crisis. The situation has grown progressively worse in the interim and it will grow still worse. Any improvement in the offing will be slight, though welcome, in relation to the enormity of the problem.

A community which cannot provide its citizens with the minimum guaranties against the hazards mortally implicit in a lack of hospital beds stands self-accused of civic negligence. We must bestir ourselves by the best means indicated to correct this truly desperate situation.

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[From the Courier-Journal, Louisville, Ky., October 19, 1946]

## Health-Service Crisis Is Near, Phair Warns—Recounts Incidents of Inadequate Care At Hospital; Special Board Parley Called

(By Grady Clay, Jr.)

A crisis in Louisville's health problem is fast approaching, and General Hospital "can't begin" to handle the city's medical needs with only 300 beds, Health Director John J. Phair said last night.

To thrash out what has "suddenly grown into a very acute problem," the city-county health board will hold a special meeting next week.

Board members at their regular meeting yesterday heard Dr. Phair recount incident after incident of inadequate medical care under the present health budget:

A 65-year-old man with a broken hip was turned away from the hospital. "No beds available." Another patient with a broken arm was rejected for the same reason.

### EMERGENCY SECTION HAMPERED

A 96-year-old Negro woman with a broken pelvis was held for 8 hours in the emergency room because no hospital bed was available at the time.

Other patients have been kept in the emergency room for as long as 48 hours for the same reason. This has caused "crowding, and inefficiency" in the emergency section, hampering its operations.

As soon as cold weather hits Louisville, bringing the annual rise in respiratory diseases (colds, flu, pneumonia), it'll be "worse than ever," Phair continued.

### DIFFICULTIES PREDICTED

"We predicted and knew this would happen last June," Phair declared. (He referred to the health board's failure to obtain a large budget from the board of aldermen. At that time General Hospital's service was cut from over 400 to 300 beds. Waverly Hills Sanitorium curtailed its work, and other health services were pared.)

Dr. Phair reported that the first pay plan at Waverly Hills started October 1 because of the need of money. A total of 290 patients were classified as "free," and 69 able to pay.

Phair estimated paying patients would yield "very roughly $27,000 a year."

### NURSE SHORTAGE REPORTED

Dr. M. J. Henry, board president, declared "We can't do nearly the job required of a public health department with the funds we've got."

Dr. Phair also reported an increasing shortage of nurses. Three more left General Hospital this week, he said.

He gave the board a comparative statement of 1945 and 1946 operating expenses for the month of July, August, and September:

General Hospital required $206,626 to care for an average of 314 patients daily in 1945.

This year, for the same 3-month period, it needed $220,980 to care for an average of only 217 patients daily.

At Waverly Hills, food costs have increased from $54,448 to $56,158 for the same period. Yet the average patient census has dropped from the 1945 level of 443 daily to 318 patients.

"All our savings in cutting the number of beds have just been eaten up with higher food costs," Phair declared.

Board member J. J. Egan suggested cutting preventive services to make ends meet. Phair said "We're doing a wrong to the whole city if we cut preventive care." Dr. Lee Palmer said it would "increase our costs in the long run."

### APPROVES SURVEY

Since the cuts took place July 1, General Hospital has been trying to handle more "out-patients" who could come in for treatment and then go home without using a bed. Dr. Phair has maintained consistently that "If we can catch people before they get too sick, we can keep them on their feet, and out of the hospitals."

The board also—

1. Accepted an anonymous gift of $50 "for the female ward" of General Hospital.
2. Approved plans to survey city-county restaurants and milk plants after October 27 to see how they comply with health regulations.
3. Approved spending $2,500 for a free X-ray program during the current V. D. case-finding campaign in the city and county.
4. Approved in principle a plan whereby the board would assume liability in case a citizen were injured or killed by a health department vehicle.

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[From the Beacon Journal, Akron, Ohio, May 18, 1947]

## HOSPITALS' GRIPES

A trace of selfishness is apparent in criticism of the Veterans' Administration's hospital program by the American Hospital Association.

The AHA thinks VA should stop building hospitals because it has plenty of capacity for service-connected cases. And non-service-connected disabilities, in the AHA view, should be treated in private hospitals at the veterans' own expense. Furthermore, the private hospital group complained, VA is unfair competition—it is paying doctors too much.

Taking up the criticisms in order—

VA hospitals already have a waiting list, and if experience after the last war is a criterion, the load of service-connected disabilities will continue to rise for another 25 years, at least.

Congress after all these years has yet to lay down a policy on treatment of non-service-connected disabilities. Pending a decision that victims of such disabilities must use private hospitals, VA had better take as many cases as it can, for the private hopitals are overcrowded, too.

Whatever it takes to attract the best doctors, that is what VA must pay. If disabled veterans are entitled to anything at all it is to the best medical care that the Nation can provide.

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[From the Gazette, Billings, Mont., January 22, 1947]

## HOSPITAL STANDARDS

Tightening up of requirements for approval, and a postwar let-down or lethargy in some hospitals are cited by the American College of Surgeons for the disturbing fact that, for the first time since hospital standardization was inaugurated in 1918, the number of approved hospitals declined during 1946.

The decline was not great, dropping the approved total by only 63, from 3,181 in 1945 to 3,118 in 1946. Billings can draw satisfaction from the fact that both local hospitals, Deaconess and St. Vincent, remained on the approved list.

But hospitals are more than a local concern. Since they have a vital influence on the general health of the Nation, they are a matter for national concern. Therefore, it is appropriate to note the causes of the decline in the standards of 63 hospitals elsewhere in the country.

Major deficiencies now interfering with good hospital service are inadequate nursing staffs and untrained administrators, according to the American College of Surgeons. The shortage of nurses is acute, and a recent survey indicates only 55 to 60 percent of the required number of nurses is obtainable. Current enrollment in regular courses of nurses' training also is about 60 percent of the desired number of students, making it doubtful that the shortage of nurses will be made up soon through these courses.

As a result, it is urged that hospitals "admit and utilize the assistance of auxiliary nursing aid," and, in addition, "approved hospitals should provide training for such vocational nurses by means of short courses."

Regarding the other common deficiency, inefficient administration, the College of Surgeons urges that administrators be selected for their special capabilities, and not for political or other reasons. It points out that hospitals cannot be conducted on a high scientific and humanitarian plane unless the administrator thoroughly understands both the professional and business problems.

The communities can help in solving both the problems of administration and shortage of nurses. Such help will be needed if American hospitals as a group are to renew the upward trend which previously had been noted each year since 1918.

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[From the Oklahoman, Oklahoma City, Okla., February 10, 1947]

## CHARITY PATIENTS CLOG UNIVERSITY HOSPITAL'S ROLLS—DOCTORS, DESPAIRING OF SITUATION, CITE NEED FOR FUNDS

An emaciated little woman, suffering the tortures of cancer, sits in the corridor at University Hospital from 8 a. m. until noon each day.

Because one 10-block walk a day is all she can manage, she must wait at the hospital for the second of her two daily X-ray treatments at the out-patient clinic.

She is one of 1,206 indigent Oklahomans on the waiting list for hospitalization.

### SOME LESS FORTUNATE

But the cancer victim, a widow of 55, is more fortunate than a majority of those for whom the State cannot afford to provide medical care. She had sufficient funds to bring her to Oklahoma City from her home 200 miles away and to rent a room five blocks from the hospital.

"I don't know how long I'll be able to stay, though," she says. "Two dollars a day for a room soon eats into your savings.

"I have a treatment at 8 a. m. and one at noon. But I am so weak I can't walk back again, so I just sit here and wait."

A few hours in the halls where the desperately ill seek admittance to University Hospital and a check into enrollment records will explain why one city doctor who donates his services there declares the threatened closing of the hospital, so far as taking care of the State's sick is concerned, would mean no great loss.

### PEOPLE DIE NEEDLESSLY

Other doctors say:

"I don't want to find new cases of tuberculosis or cancer. I'd rather not know about them since we do not have facilities to cure them;" and;

"You talk about your traffic fatalities. Why, more people die needlessly in this State than are killed in car wrecks."

The University Hospital proper has a total capacity of 223 beds, but because of a shortage of nurses, only 175 of these are now in use.

Crippled Children's Hospital has 214 beds. Wards closed for lack of nurses leave 186 beds available.

These are all full and 510 children (orthopedic, ear-nose-throat, plastic surgery, pediatric cases) are waiting for a vacancy.

### LIST DATES TO 1942

The 1,206 adults on the general hospital's waiting list include all types of cases. Many of them first tried to get into the hospital in 1942.

"We check up every now and then to see if they are still waiting or are still available for treatment," a hospital official said. "Often we find they have gone elsewhere for treatment or have left the State."

Others are just "not available for treatment." They are dead.

Some 3,000 persons per month are treated in the hospital's out-patient clinic. Since this is the only general clinic in the city for patients with common ailments, approximately one-half of the patients are Oklahoma Citizens.

Ten percent of these, authorities say, need hospitalization.

### NURSES ARE NEEDED

The hospital's admitting office was described as a "traffic department." Would-be patients are carefully screened. It it's an emergency, officials arrange for space as soon as possible.

"But," one doctor explained, "you can't throw sick people out of a hospital in order to put sicker people in."

The admitting office attempts to route the "sicker people" to other hospitals. St. Anthony takes a number of the indigent for whom University has no room. The balance go on the waiting list.

"We need beds, but especially, we need more nurses," the official said.

### MONEY IS THE CURE

Doctors on the 150-man volunteer staff, which has donated in free service practically dollar for dollar the money the legislature appropriates to run the medical school and hospital, say "there is nothing wrong with the institution money wouldn't cure."

This week there was no indication the cure would come. If the legislature follows recommendations of the board of regents for higher education, which has chopped all budget requests for the new biennium, standing of the medical school with accrediting agencies reportedly will be damaged and the entire institution faces possible abandonment.

A drop-in-the-bucket relief measure will be the new wing now under construction, providing nurses can be found to staff the 50-bed addition.

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[From the Tribune, Oakland, Calif., January 22, 1947]

## NEEDS OF HOSPITALS

It is significant that for the first time since hospital standardization was inaugurated in 1918, the American College of Surgeons is listing, following the 1946 survey, a somewhat lower number of approved hospitals than were shown at the end of the previous year's review—3,118 compared with 3,181. Up to this time a gradual upward trend has been registered each year since a total of 89 hospitals appeared on the first list published 29 years ago. The college furnishes two explanations for the slight decline of 63 in the number of approved hospitals this year. One is that during the war it was necessary, because of emergency shortages of personnel and supplies, to make certain compromises in some cases, and that now the college is again tightening up on the requirements for approval. The other explanation offered is that a few hospitals which may have made extraordinary efforts to render high-quality service during the war emergency have, like a great many other groups and individuals, experienced a sort of postwar let-down or lethargy from which they and all of us need to be aroused.

The community which is served by a hospital shares the onus when what should be an upward curve of progress in hospital care levels off or begins to turn downward. The citizens are responsible for insisting upon good hospital service and for giving the support and encouragement which are needed to provide it. Consequently, it is to the public that the American College of Surgeons directs this year two appeals in particular, concerned with deficiencies that are especially interfering right now with good hospital service, and to correct which the public can give substantial help. These deficiencies are inadequate nursing staffs and untrained administrators.

Hospitals play an important role in conservation of the lives and health of the people and should be leaders in the postwar effort to improve all welfare service. For this they must have competent personnel within their organizations. Community pride in their progress is essential to help them obtain adequate nursing staffs and to select properly trained administrators, as well as to comply with the other requirements for good hospital care.

Of assurance to the community is the fact that the College of Surgeons' list of approved hospitals, this year, as usual, includes the names of all of our leading institutions.

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[From the Oregon Journal (Independent), Portland, Oreg., February 4, 1947]

## HOSPITAL BEDS

Hospital rates in Portland have been hiked again. The daily charge for a bed in a ward is $8 where it was $7. More true, thus, than when it was printed on August 8, 1946, is the following editorial comment of the Journal on that date:

"To the person of moderate means who has not made advance plans by some form of prepayment, a hospital experience with physician services added, becomes a financial catastrophe."

Would it be possible, for the sake of people of moderate means who, nevertheless, desire to pay all they can afford, to set aside a floor in the Multnomah County Hospital?

This question was presented to Frank L. Shull, chairman of the Multnomah County Commission. He answers:

"The hospital was built in order to serve those not financially able to pay for hospitalization. This did not preclude caring for pay patients, but the latter were not taken when facilities were available in other hospitals, until during the war when there were beds available in the county hospital not required for the indigent. Then, when beds were not available in private hospitals, some pay patients were taken at the county hospital.

"In recent months there have been more of those not able to pay than beds available. This was partly because of the fact that the manegement was not able to secure enough nurses to serve all of the beds in the hospital. Since the first of the month (January) several nurses have been secured and there are now only about 15 beds not in use.

"There have always been some who were not financially able to pay for service in private hospitals and these have been cared for in the county hospital. The management would no doubt be subject to criticism if it accepted pay patients and thereby was compelled to refuse admittance to those without funds."

Commissioner Shull's comment states the case but does not close it. There should be a way to hospitalize sick people who want to pay all they are able, but are not able to pay the high rates in the private hospitals. No sick person should be without a doctor or because of cost be denied a hospital bed. The Multnomah County commission could with profit study the low-pay plan in the Cook County Hospital, Chicago.

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[From the Times, Chicago, Ill., January 8, 1947]

## CRITICIZE FOOD IN 76 HOSPITALS

Chicago's 76 hospitals were put under the microscope by the United States Public Health Service, and the resulting report, released today, pointed up "deficiencies in facilities and food handling."

In addition to reporting serious fire hazards, the advisory committee of the Chicago-Cook County health survey said "considerable work needs to be done" in improving the handling of food for patients.

The survey said there was evidence of "failure to supply adequate utensils and equipment, and to clean them properly, failure of adequate bactericidal treatment, the use of bulk milk for patients, improper storage of food and lack of protection against rodents and insects."

### CITE BED SHORTAGE

The report added "it is evident that the hospital dietitians and those responsible for food service need to be taught the fundamental principles of good sanitation and hygienic practices."

Turning to a discussion of facilities, the survey showed there was a total of only 315 beds available for the city's 350,000 Negro population.

It was estimated that 2,760 beds are needed in Chicago for the Negro sick plus 1,648 additional bends for tubercular patients and 1,278 for mental patients.

The report recommended that race, color, or creed barriers and segregation be eliminated by all hospitals and that their staffs and training courses be opened to all qualified individuals.

### "A TREMENDOUS JOB"

Cook County, the report continued, needs approximately 4,500 extra hospital beds for acute cases. On a county-wide basis 3,500 more beds for mental patients, 2,000 for tuberculars and 6,000 for chronic invalids, are needed.

Approximately 900 of the new beds, the report continued, should be in public hospitals.

The report said that generally Chicago and suburban hospitals were "doing a tremendous job * * * in view of present-day problems.

One recommendation of the investigators called for establishment of an eight-man over-all administrative commission to be created to operate all tax-supported hospitals and sanitariums in Cook County. They also called for emergency ambulance service.

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[From the Sun, Chicago, Ill., January 9, 1947]

## POOR FOOD HANDLING, LACK OF BEDS ALSO CITED IN UNITED STATES REPORT

Chicago hospitals need better fire inspection, more sanitary food handling methods, additional beds for patients, and better over-all planning to make the best use of their facilities.

That was the analysis made yesterday of the 76 institutions in the city and 19 in Cook County studied by experts of the United States Public Health Service in their public health survey report.

### FIRE REPORTS CRITICIZED

The way in which the city fire marshal's office handles hospital reports was criticized on the ground that 42 inspection reports were missing and that there was poor work in following up complaints of definite fire hazards.

"In some instances many months pass without anything being done to remedy the dangerous conditions," the report states.

### HAZARDS NOT CORRECTED

Investigators for the health survey visited several hospitals, found hazards described in fire department reports had not been corrected, and discovered the existence of others.

These included lack of proper fire escapes, rubbish piles in basements, blocked fire escape doors and corridors.

No names of hospitals were cited. Chief Fire Marshal Anthony J. Mullaney denied that there had been laxity as charged. In county hospitals outside the city limits, inspected by the State fire marshal's office, conditions were much better, the report stated, with regular inspections and follow-through to ensure corrective steps.

### FOOD HANDLING CRITICIZED

In food preparation and handling there is room for improvement, the report states, adding:

"Some hospital kitchens violated the Federal standards for cleaning of utensils and equipment, others used bulk milk for patients, stored food improperly, or lacked protection against rodents, vermin and flies."

City food inspectors have failed to make regular inspections of hospitals, it is charged.

### 16,000 MORE BEDS URGED

To correct the shortage of hospital facilities the report recommends that there be provided a total 16,000 more beds; 4,500 for acute medical and surgical cases, 3,500 for nervous and mental patients, 2,000 for tuberculous patients, and 6,000 for chronic invalids urged in other sections of the report.

To prevent waste of "time, money and effort" in the work done by hospitals, two steps are urged.

One is the creation of an eight-man commission by law to run all public hospitals in the city and county, in place of the present provisions for control varying from institution to institution.

### EXECUTIVE TO SURVEY WORK

The proposed eight-man directorate would be empowered to hire an executive officer to see that the various tax-supported hospitals worked together to satisfy the needs of the community.

This officer also would have control of the proposed expanded emergency public ambulance service. Another need, it is stated, is more hospital beds for Negroes.

The second recommendation for bringing about better coordination is establishment of a planning group for all nongovernmentally supported hospitals which now often give overlapping or competing services.

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[From the Times, Kansas City, Mo., December 6, 1946]

## Later Splash for Sick—Hospitals Here Consider a New Schedule—If Plan Is Adopted, Patient No Longer Will Be Awakened at Dawn With Wet Cloth Across His Face

To all former hospital patients who have been awakened at 5 or 5:30 o'clock in the morning by the swish of a wet washcloth across the face, the report that hospitals in the Kansas City area are to consider a later opening hour will come as good news.

The dawn bath ritual has left a deep imprint on the minds of many persons accustomed to later rising hours who have made visits to hospitals for anything from a tonsilectomy to a broken shoulder. In a more or less stupefied condition after being jarred from sleep, the patient usually finds he or she is wide awake following the bath—awake with time heavy on his hands.

Dozing off again after a half hour of wakeful boredom, the patient feels at peace only to hear the rustle of dishes and the announcement, "Breakfast."

### BREAKFAST AT 7 OR 7:30

Should the hospital administrative executive deem it worth while to make the time change, a 6 or 6:30 o'clock breakfast will be delayed until 7 or 7:30 o'clock; lunch and dinner will be scheduled more nearly at the hour recognized as appropriate; and, it is hoped, happier patient and staff relations will exist.

The idea is not original with Kansas City, Hal Perrin, business manager of the General Hospital, pointed out yesterday. Several other hospitals, including such widely known medical centers as New York Hospital in New York City, Wesley Memorial Hospital in Chicago, and the Roosevelt Hospital in New York have tried the modernized arising plan and proclaim it entirely workable.

Quoting from a recent issue of Hospitals, the journal of the American Hospital Association, Harriet Smith, director of nursing at the Wesley Memorial Hospital, stated:

"A practice in hospitals which smacks of dark ages is the idea that the day must begin at 7 a. m. or earlier. That witching hour probably was the product of poor street lighting, inadequate transportation, and the system of housing all personnel on the premises. In the last 10 or 15 years, we have for the most part done away with all those features while still retaining the old starting time."

### WORK IN 8-HOUR SHIFTS

Perrin explained that in most Kansas City hospitals, and for that matter, hospitals in this entire area, the working day is divided into three shifts—the first rununing from 7 a. m. to 3 p. m., the second from 3 p. m. to 11 p. m., and the third from 11 p. m. to 7 a. m.

Under the later opening hour plan, he continued, the three staff changes would be made an hour later—the first starting at 8 a. m. and so on. It would allow the hospital personnel on the early shift time to wash faces, brush teeth, and serve breakfasts at a later hour.

And, in turn, the plan would allow the patient, at the mercy of hospital regulations, an extra hour's sleep.

Perrin related that among other added features of the shift in hours would be a delay in the dinner hours which normally are scheduled from 4 to 5 o'clock in the afternoon. This, he added, oftentimes has resulted in a siege of hunger on the part of patients along about 9 o'clock, shortly after which time is "lights out" on the hospital docket.

### OPERATING TIME A PROBLEM

Balancing the advantages, Perrin hastened to explain, is a rather formidable list of disadvantages. Prominent on that list is the problem of morning operations.

"Doctors prefer to perform surgery early in the morning while they're fresh," he commented. "They usually make their hospital rounds shortly after 8 o'clock and this could result in confusion for both the doctor and the patient. I imagine surgery schedules could be left as they are now."

Perrin expected that other disadvantages would be brought to the fore at 2 o'clock Wednesday afternon when the Kansas City Area Hospital Council meets at the University of Kansas Hospital to discuss the change of hours.

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[From the Herald Tribune, New York, N. Y., May 15, 1947]

## HOSPITALS' PLIGHT—VOLUNTARY INSTITUTIONS FACE FINANCIAL DILEMMA

*To the New York Herald Tribune:*

Letters from several professional nurses' organizations have appeared in the New York papers commenting on some statements I made before the Academy of Medicine in a discussion on the responsibility of the hospital trustee to his community. Only one of these letters was fair enough to say that I might have been quoted out of context.

My plea that afternoon was: How can the sick in the low-income brackets be assured that hospitals will stay open? For with costs rising as they are today and with all hospital workers (nurses, cooks, elevator men, etc.) receiving more pay for shorter hours, all voluntary, nonprofit hospitals are in financial peril and their trustees worry how long it will be before they have to close the doors.

The voluntary hospitals have never made a profit. Because the great bulk of the work they do is free or at less than cost, they wind up every year with a substantial deficit—a deficit that can be erased only by private donations. Today, of course, these deficits are higher than ever. A study made by the United Hospital Fund of rising costs in 53 hospitals shows that between the years 1940 and 1945 food advanced approximately 50 percent and labor approximately 60 percent. It is the responsibility of all trustees to see that their hospitals survive somehow and whether they continue also depends a great deal upon all hospital workers.

This hospital dilemma holds true of any American enterprise. But whereas industries can raise their selling prices to meet the mounting cost of labor and materials, the hospital cannot. The cost of being sick is already too high for the majority of our people, and if it continues at this rate of increase, people will not be able to raise the money to meet hospital expenses. The case of voluntary hospitals is only a symptom of the larger social and economic problem facing this country today.

None of this implies, as these letters have accused me of stating, that nurses have failed to do their duty in the past. No one is more aware than the hospital trustee of the devoted and indispensable service that nurses have been giving, both those in the war and those doing double duty on the home front. The only danger is this—that if the hospitals price themselves out of business on an

8-hour schedule which automatically increases labor costs throughout all the departments, the nurses will suffer among the first.

The hospital trustee requires no defender. With but little encouragement, support, or understanding on the part of the communities which these nonprofit hospitals serve, hundreds of devoted men and women trustees are giving tirelessly of their time after regular business hours to the study of one of the most pressing problems before our country today.

Neither should hospital management be baited by bringing up the sad but true comparison between the rates paid to skilled versus the unskilled workers of today. The devoted nurse, the overworked teacher, the tireless doctor, the minor executive—they all receive less than the mason, the domestic worker, the truck driver and many a white-collar worker. Surely, the hospital trustee cannot be blamed for this.

We must all work unitedly for the survival of the modern, voluntary hospitals to make it possible for them to employ more nurses, but most of all so the doctors may have independent centers of medicine in which to practice their art and in which they may teach the student of tomorrow the latest wonders of medical science.

NEW YORK, *May 12, 1947.*

WILLIAM H. ZINSSER,
*President, Board of Trustees, Lenox Hill Hospital.*

Senator DONNELL. Our next witness is Father Alphonse H. Schwitalla, of St. Louis, Mo.

Father Schwitalla, before entering upon your testimony, would you be kind enough to state your own personal education, background, and experience, please?

## STATEMENT OF FATHER ALPHONSE M. SCHWITALLA, S. J., ST. LOUIS, MO., PRESIDENT OF THE CATHOLIC HOSPITAL ASSOCIATION

Father SCHWITALLA. First of all, I am a Jesuit priest, a Catholic priest, and member of the Jesuit Order. I am dean of the school of medicine at the St. Louis University, and in St. Louis, I am chairman of the university hospital board and I am chairman of the council of four other hospitals in St. Louis.

Senator DONNELL. Would you tell us in a word something about the volume of hospitals in St. Louis and whether or not it is recognized as a notable general hospital center in the Nation?

Father SCHWITALLA. I think we are rather well proud of St. Louis as a hospital center and as a medical center. There are 2 great universities, 2 medical schools, educating from the 2 of them roughly 200 or 250 graduates each year—graduating that many—and we have 42 hospitals in the city, 36 of which are general hospitals. So that I think we have rather a lot of information in St. Louis about hospital matters. At least it is accessible, and a man would have to be almost stupid if he didn't pick up some little knowledge about hospitals just casually if he lived in St. Louis.

Senator DONNELL. Father Schwitalla, you were referring a moment ago to the number of Catholics that were connected officially with the organization, and I think I interrupted you.

Father SCHWITALLA. I have that in my statement, if the Senator agrees to wait that long.

Senator DONNELL. All right, Father, you may proceed.

Father SCHWITALLA. It is my deeply valued privilege to appear before this esteemed committee on a matter which profoundly affects the national welfare. Since the reports of this committee's hearings have permeated through the country, public attention has been called to the singlemindedness and high purpose of this committee and of its members. I value the privilege of appearing here, since I represent, by formal action of its administrative board, the 775 member hospitals which comprise the membership of the Catholic Hospital Association of the United States and Canada, and the 300 to 400 additional institutions. There are working in those institutions more than 22,000 Sisters who have given their lives to the safeguarding of the Nation's health and welfare, with no earthly remuneration than the merest necessities in living conditions.

The 775 Catholic hospitals in the United States constitute 17.6 percent of all the hospitals under nongovernmental control. Their beds constitute 27 percent and their patients 32 percent of all of the hospitals under nongovernmental control. This group of hospitals admitted last year not fewer than 81 percent of the patients admitted to hospitals under church control. The patients are not all Catholics, needless to say. Last year the Catholic patients constituted only 43.1 percent of the 3,149,000 patients admitted into the Catholic hospitals.

This group of institutions and the Sisters are actively interested in the issues which center in Senate bill 545, introduced by Mr. Taft for himself, Mr. Smith, Mr. Ball, and Mr. Donnell. I am proud to find the name of the Honorable Mr. Donnell associated with this bill, since many persons in Missouri, especially those in medical and hospital groups, have had the high regard in which they hold Mr. Donnell corroborated by the magnificent services he rendered in the interests of national health through his thorough and penetrating inquiry into the implications of a national health bill during the Seventy-ninth Congress.

Senator Donnell. May I interrupt at this point, Father? I want to express by great appreciation of this very fine tribute, coming as it does from an old friend and a gentleman in whom I have so great confidence and a gentleman whom I hold in such high esteem. I greatly appreciate this, and I want to assure you that the other members of the committee are laboring earnestly and diligently to produce something that would be worth while in the deliberations of this body.

Father Schwitalla. I should have also added, Senator, this comes from a neglected Democrat. [Laughter.]

Senator Pepper. I hope, Father, that your noble friend will more closely in the future follow your noble leadership. [Laughter.]

Senator Donnell. I am sure, Father, that my friend from Florida is not at all lacking in his efforts to bring about that result. [Laughter.]

Father Schwitalla. I didn't think we were going to put up the ropes this early.

Senator Pepper. I want to add your esteem for the Senator from Missouri is unanimous.

Father Schwitalla. We all love him.

Senator Donnell. I certainly appreciate Senator Pepper's observations.

Father Schwitalla. I was glad I was able to bring out that testimony.

Senator DONNELL. I never had that on record before, but he has been extremely diligent and helpful in the work of this committee for a long period of years. Proceed, Father.

Father SCHWITALLA. The purposes of the act:

Senate bill 545, which is now cited as the National Health Act of 1947, approaches the problem of the national health along a new avenue. It does so by plunging boldly and courageously into the very center of one of the great difficulties in the health area which has confronted the Nation and which, presumably, must have cost the Federal Government large sums of money in administrative expense and salaries, namely, the problem of the multiplicity of Federal agencies concerned with health, for the coordination of which agencies, S. 545 purports to provide. The adequate coordination of the health functions of Federal governmental agencies is expected to facilitate the expansion of the activities of the Public Health Service and to promote and encourage both medical and dental research in the National Institute of Health and in the several States, through grants-in-aid; and finally, in addition to other purposes, to bring about the construction, in the National Institute of Health, of a Dental Research Institute.

The bill exhibits a distinct feature since in its preamble, if Congress were to pass this bill as it now stands, Congress would declare itself as finding and would assert four principles or declarations upon which presumably all that follows in this bill is thereafter predicated. The declarations are not trite or axiomatic or, for that matter, universally acceptable principles. As I read them, they are rather challenges to both the legislator and to the general public. As a student of hospital science and medical care, and as one interested in national welfare policies, I wish hereby to express my satisfaction over the four principles which by implication have been found basic in the present bill.

I cannot, however, accept these with too facile an acquiescence. If it is stated in the first of these principles that health and medical functions are scattered among the agencies of the Government with resultant confusion and duplication of effort, it may also be true that through a concentration of effort and through resultant action by prescription, there may be a stifling of initiative, a coercion of independence and a concentration of power which must by all means be guarded against. Duplication of effort and apparent confusion are subject to criticism only when out of all of this there should grow as the last result, a noteworthy wastage in manpower and serious misunderstandings preventing proper cooperative effort. As a general principle, I welcome the kind of reorganization here proposed and I feel certain that the realization of the plan will be conducive to greater effectiveness and economy.

Secondly, if the bill passes as it now reads, the legislators will be called upon to declare their approval of the principle "that there are inadequacies in the distribution of public-health services and of medical and dental services," resulting in the inability of some persons to secure the health and medical services which they need. It would seem to be true that even with any conceivable reforms, there would still remain inadequacies and uneven distribution of health services; and even with the best possible distribution, not all the persons who need health and medical services will find them equally accessible and available. After all, it is probably true that the implication of the statement is somewhat idealistic. The beginnings we have made through the Hospital Survey and Construction Act promise well for future legislation, and I hope to see the spirit of that legislation carried over vividly and efficaciously into this National Health Act of 1947.

Senator DONNELL. Pardon me, Father. The act you refer to is the Hill-Burton Act?

Father SCHWITALLA. That is right.

Thirdly, Congress is asked to declare on the basis of its convictions:

> that it is the policy of the United States to aid the States through consultative services and grants-in-aid to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status.

It is really the policy of the United States to do this? It is only within the last year that we have passed the Hospital Survey and Construction Act, the first major acknowledgment since the creation of the United States Public Health Service on the part of the Federal Government to prove that it—the Government—is concerned with the problem of making available to the individual States the funds for the development of greater facilities. It is important to find that this statement might really be considered a statement of fact at the present moment, but is it really our objective to make available to the States the funds for the equalization of opportunity for all citizens to avail themselves of accessible medical, hospital, dental, and public-health services, regardless of race or economic status? If this statement of objectives is to be taken seriously, it certainly lays down a long-range program for the attainment of which this bill makes significant but only partial provision. Personally, I would seriously question the feasibility of the purpose proposed in such a statement.

Lastly, it is said "that it is the policy of the United States to make provision for voluntary deductions from the salary of Federal employees of premiums directed by them to be paid to voluntary nonprofit health insurance funds." The intent of this declaration is very evident. Its purpose is to remove any coercion with reference to enforced deductions from salaries as payments of premiums for health or hospital care in such agencies as the Blue Cross. The statement will undoubtedly merit the approbation of those who are anxious for the extension of the voluntary nonprofit prepayment plans for both hospital and medical care, especially among Government employees.

## THE NATIONAL HEALTH AGENCY

It is hard to conceive how anyone would care to take issue with the great administrative reorganization in the health field provided for in title I of S. 545. There can be little if any doubt but that a concentration of responsibility for the interests and obligations of the Federal Government in the field of health should result in almost indescribable advantages in financial savings, in unification of effort, in simplication of procedures, and in the more effective prosecution and attainment of goals. One cannot reasonably question the advisability of the National Health Administrator being an appointee of the President, a full-time official of the Government and particularly a doctor of medicine licensed to practice in one or more of the States, and a man who is outstanding in his field. We recommend, however, that the National

Health Administrator have a National Health Administrative Council to advise and concur with him in the major phases of the provisions of this act, including—

(*a*) The appointment of the Directors of the Divisions specified in section 104;

(*b*) The formulation and promulgation of regulations controlling the general policies of the Agency;

(*c*) The expansion and extension of coordinate units or divisions and their functions.

We recommend that this National Health Administrative Council be composed of eight members who shall be nongovernmental persons of experience and outstanding ability in the fields of the various departments set up in section 104, whose outlook and viewpoint are commensurate with the seriousness, dignity and intimacy of the Nation-wide problems dealt with in this legislation which affect every one of the 135,000,000 individuals in the United States in their relationship with their doctors. The National Health Administrator should be ex-officio Chairman of this Council. The establishment of this National Health Administrative Council will relieve the National Health Administrator of the overwhelming burden of making such momentous decisions on his own responsibility and will place at his disposal the advice of competent, disinterested, and experienced advisors.

Senator PEPPER. Mr. Chairman, if the Father will allow my interruption, I have been called by the Appropriations Committee to appear on some matters affecting my State, and I will have to go. I want to apologize, Father, for the necessity of my departure, and I want to say we are always glad to have you come and give us your views.

Senator DONNELL. I am sorry to see you go, Senator.

Father SCHWITALLA. The cancer problem: No one who grasps the magnitude of the cancer problem and its far-reaching implications can fail to be impressed with the desirability of the provisions contained in section 203 of the bill, where there is authorized to be appropriated for the next year and each fiscal year thereafter the sum of $10,000,000 for the purpose of developing more effective measures for the prevention and control of cancer. If any criticism could be made of this section, it would be chiefly with reference to the amount which is authorized to be appropriated. But before I would endorse such criticism, I should want to know what the total amounts are under other legislation as well as under the present, which the Government is appropriating for cancer control, prevention, and research.

In the absence of such knowledge, I can only say that we cannot spend too much money for this purpose, so great and urgent is the need and so overwhelming is the intricacy of the problem. Ten million dollars for the investigation of what the layman thinks of as a single disease because to it can be attached easily a single name, may seem to be an enormous amount of money. One hears criticisms from time to time about the unwise scattering of funds for cancer research and cancer control. There is, of course, an enormous enthusiasm among cancer workers and a great dedication to their life's purposes and an almost heroic attachment to the cause in the face of all but incredible obstacles. But when all is said and done, the layman today, even one who recognizes all the difficulties, seems to be expect-ing too much in a hurry and he cannot understand at times the great need for continued long-range support.

As has been suggested more than once, after having bought the atomic bomb by incredibly large appropriations for support of research, we are apt to think now that we can buy the solution of the cancer problem, forgetting altogether how entirely different are the two problems and how entirely different must be our approach to both of them. I can only say that every penny that might be given to the support of the cancer program should be voted by Congress and by the people with ready enthusiasm and with willing promptness.

### MEDICAL SERVICES FOR FAMILIES AND INDIVIDUALS WITH LOW INCOME

This brings us to a discussion of the welfare purposes of this new legislation and of the means it suggests for the achievement of those purposes. Briefly, I am in complete accord with the entire concept of attempting to meet the problems of general health, hospital, and medical services for families and individuals with low income through a public-assistance program, identical with or similar to that created in the new legislation.

I take this position because, first of all, in paragraph 711 the authors of this bill explicitly declare—

> In order to assist the States to provide general health, hospital, and medical services for families and individuals with low income in accordance with the provisions of this title, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, and for each of the four succeeding years, the sum of $200,000,000.

The authors of this bill undoubtedly intended that through these provisions of paragraph 711 they are implementing the program announced in paragraph *c* of section 2, where they say that Congress finds and declares—

> that it is the policy of the United States to aid the States through consultative services and grants-in-aid to make available medical, hospital, dental, and public-health services to each individual, regardless of race or economic status.

It is palpably clear that the authorization for the appropriation of $200,000,000 annually for 4 years cannot possibly achieve the ideal of Nationwide dimensions suggested in paragraph *c* just quoted and that, therefore, it intends to attack the problem of national health care at the point and in the area of greatest need, namely, at the level of the low-income group of the population. This seems a logical point at which to attack the problem of the national health.

I am taking the liberty of quoting a previous statement which I made on behalf of the Catholic Hospital Association and which expresses principles upon which much of the legislation projected in S. 545 might well have been based. Permit me to quote:

> In Catholic thinking, government should have a minimal rather than a maximal effect. Hence, too, government will be ready to assist those who cannot be responsible for themselves or who lack means to exercise that responsibility. It will never force its assistance upon those who have the capacity and the means to carry their responsibilities for themselves and their dependents. The measure of a man's need only will be the measure of the Government's subsidy and such a subsidy will leave untouched and unimpaired the self-respect of the individual. The principle of minimal interference by government must here become operative and the Government will refrain from interference where personal initiative and self-realization can effect the results required by a national or a personal need.

First of all, the bill contemplates grants to the State for the specific purpose of providing general health, hospital and medical services for families and individuals having a low income. In this broad statement of the purposes of grants to the States, there is fortunately no limitation as to the nature of the services which are to be made available to low income groups through these grants, nor is there a limitation as to the meaning of low income to either families or to individuals, nor is there a restriction of the benefits to individuals alone or to families alone. I welcome this broad concept of the nature of the services, of the definition of the beneficiaries and of the conditions for participation in the benefits of the law particularly when I note that the same liberalization seems to have been carried out into the details of the legislation.

In section 712, there are defined the requirements demanded of a State for taking advantage of the benefits created by the bill. To qualify for such participation, a State must, of course, conform to certain standards. It is true that in the requirements for organization, certain necessary definitions must be introduced. Thus there must be a single State agency as the administrative agency, and personally, I welcome the requirement that before 1949 that agency shall be the State health agency, though I can see the arguments of others who might prefer that this matter be left to each individual State to determine. It would seem to me that the chief argument for ultimately restricting responsibility for the administration of the benefits to the State health agency arises from the fact that the State health agency will have the closest relationship to the United States Public Health Service which, first of all, has done so much to merit the confidence of the country particularly under its present administration; and which, secondly, is to be integrated as the chief and most effective component of the new National Health Agency created under title I. Secondly, I approve and endorse personally the creation of a State medical and hospital care advisory council in which there shall sit representatives both of governmental and nongovernmental organizations.

Evidently, the thought behind the concept of such an advisory council includes the fundamentally sound concept that in an advisory group, there should be adequate participation in planning, program-making and supervision of those who are professionally competent to render service; secondly, of those who are responsible for the administration of the service rendered; and thirdly, of those who are the recipients of the service or who represent special interests of the recipients. There can be no question about the desirability of the third rquirement, namely, the requirement that the State agency designated for the administration must be endowed with adequate authority to carry out the State plan.

The fourth requirement in the State program must be approached with caution and careful evaluation. The provisions of this requirement are the very heart of this legislation and there are amalgamated here more intricate points, any one of which might become highly controversial, than one would think at first reading. Omitting for the time being the question whether what is required in this paragraph can be effected in 5 years, I should like to raise a number of problems and whenever possible give the answer in terms of the legislation itself.

First of all, can we supply hospital services, surgical services, and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such? A legislator will answer that this point is to be determined by making the medical care survey for which under title VII, section 701 to 703, inclusive, provision is made, and for which there is authorized to be appropriated to be distributed to the States the sum of $3,000,000,000.

Secondly, what will be the level of completeness and adequacy of the hospital services, medical services, and surgical services to be furnished? This question suggests that the National Health Administrator or the Director of Medical and Hospital Care Services will have to be given power to write such rules and regulations as may be necessary, on the one hand, to safeguard minimally the health of the families and individuals of whom there is question and, on the other hand, to give them that measure of health care which modern medicine and modern dentistry are today capable of giving The powers conferred upon the National Health Administration in sections 101 and 102 seem to be sufficiently broad to include the regulatory power of the National Health Administrator assisted, I should hope, by his National Health Administrative Council.

A third question occurs concerning the insufficiency of the income to the families or to the individuals which is being used as the basis of the rights to these hospital, surgical, and medical services. "Sufficiency of income" is, of course, a relative term just as the "cost" of hospital, surgical, and medical services is a relative term and the correlation of sufficient income with the cost of health-caring services admits of the widest possible latitude of interpretation and administration.

Despite all of this lack of definiteness, I would not counsel a more sharp definition than is given in this paragraph since we cannot but recognize that in each State and in each combination of circumstances, these various provisions will necessarily be given a differential quantitative significance and through such interpretation will be more useful to serve the differential purposes of each State locality.

I should like to make the same remark concerning physical examinations for all the children in the elementary and secondary schools of the State. Standards can be written for physical examinations, but here again the framers of this legislation have, to my mind, wisely refrained from entering into unnecessary details. I hope, however, that the service implied in giving periodic physical examinations is to be extended to all the children in the elementary and secondary schools, and that the understanding of the legislators has been to include the children of both public and nonpublic schools.

In the second part of the fourth requirement for a satisfactory State-wide program, other provisions are made with which I find myself in complete accord. I welcome the liberal attitude implied in the requirement that services to the beneficiaries of this law may be rendered in institutions, in the home or in physicians' offices. Hospitals and schools, I think, should be specifically mentioned in this place.

Furthermore, the provision will merit the commendation of professional persons engaged in the health field that the services may be furnished to families and individuals either as services or as payments in the nature of premiums or partial premiums, or as reimbursements of expenses previously incurred. And, thirdly, the same professional persons will wholeheartedly and enthusiastically endorse the provision that payments may be made for services rendered to a voluntary health, medical, or hospital insurance fund, or other fund operated not for profit. Of course, there will be questions raised about all of this but there will be a human and a humane approach to situations which have distinctly human values in them and which should, therefore, be approached in a sympathetic and understanding manner.

It is the part of wisdom to provide for supplementing the payment for hospital, surgical, and medical services by families and individuals who are able to pay only partly the costs of such services, through funds appropriated by the Federal Government to the States.

A further commendable feature in the provisions of the fourth requirement (sec. 712) permits the payment for services rendered not only by governmental agencies, such as the tax-supported health-caring institutions, but also by the private agencies. And, lastly, with reference to this paragraph, the provision deserves the fullest and most enthusiastic endorsement that the program—

> may also include payments to physicians practicing in areas which, without such payments, would be unable to provide sufficient income to attract a practicing physician.

Two considerations remain concerning the common-sense provisions of this fourth requirement for the State-wide program. The first is whether the size of the appropriation as provided for in section 711 is sufficiently large to permit the achievement of all of the objectives in their liberalized form, which have just been summarized; and the second is whether all of this can be achieved within 5 years. The financial considerations, however, I prefer safely to leave to the budget makers. The chronological considerations are another matter; and though I am entirely hopeful that the comon-sense provisions of this legislation will make its appeal to the pragmatic sense of the American people, I still have my fears that those who would lean more heavily upon the Government might possibly have expected more. It may still be that those who desire to throw their responsibilities upon the Government rather than to receive supplementation from the Government may prove unfriendly to phases of this legislation no matter how praiseworthy in itself, commendable, and humane it may really be, and thereby delay the execution.

The other requirements for the approval of the State-wide program which make it acceptable to the National Health Administrator—namely, the basing of suggestions on existing inventories of medical, surgical, and hospital facilities inclusive of the tax-supported and private agencies; the preparation and submission of reports as demanded by the appropriate officials, and the periodic review of the plan—are, of course, common-sense elaborations of generally accepted administrative provisions.

Similarly, there may be added here for the purpose of completeness general approval without commitment as to details of the functions of the Director of Medical and Hospital Care Services, of his obligations for reporting, and of the appeal procedure which has been devised. The National Medical Care Council conforms to commonly accepted patterns.

### DENTAL HEALTH SERVICES

Since, in the interest of public health, the whole neglected area of dental care is so intensely important, I wish hereby, even though I be without competence, to express my gratification over the fact that such ample provision is made for dental service to school children, and to families and individuals having low incomes. The provisions for a dental survey and the provisions for insuring dental services are admirable in their intent, indispensable in their effect upon the general national health, and absolutely necessary to guarantee the expenditures which are provided for under title VII for the general health of the people. In the same way, the sponsors of the bill are to be commended for their forward-looking provisions providing for funds for dental research.

### CONCLUSIONS ON THE STATEMENT OF THE CATHOLIC HOSPITAL ASSOCIATION ON S. 545, THE NATIONAL HEALTH ACT OF 1947

In the review of this legislation which I have just concluded, certain features stand out as worthy of special emphasis and commendation. The Catholic Hospital Association has embodied its attitudes on national health legislation in the resolution which it adopted at the end of its annual conventions year after year for the last 15 years and more. We have followed the development of such legislation in Congress and in all State legislatures and have restated, modified, or reemphasized our position from year to year as new light was secured or viewpoints developed on the national interests in health care.

Not casually, therefore, but with full realization of the implications, I wish to endorse Senate bill 545, my reasons being chiefly because—

First, this bill takes care immediately of that fraction of the population which is most in need of health care—namely, the indigent, the semi-indigent, the medically indigent.

Secondly, in giving such care to these needy persons, the bill makes adequate provision for insuring cooperation between the private and the public agency.

Thirdly, because while envisioning the health care of the American people as a national problem, it gives full consideration to local differences and to individual rights, thus facilitating the development of liberalized and locally differentiated programs in the various States and localities.

Besides there are other features seemingly of less importance but equally far reaching which offer arguments for endorsing this bill:

1. This legislation offers a wide variety of methods for diffusing the benefits of health care.
2. It insures the freedoms in health care characteristic of the American pattern of life by avoidance of regimentation of both the health-caring professions and of the people whom it seeks to benefit.
3. It initiates an orderly procedure in the development of a national health program as need and experience indicate.

4. It eliminates complicated control over health services.

5. It is characterized by a general attitude of humaneness and understanding of the low-income groups, and of the requirements of different classes of patients in different localities and circumstances.

6. It gives legislative expression to an attitude of mutual respect and sincere cooperation between government and the governed, between the tax-supported and the private agencies.

Senator DONNELL. Father, we greatly appreciate your statement. I shall not press much longer on your time, but I should like to ask a very few questions.

In the course of your statement you say this:

> The beginnings we have made through the Hospital Survey and Construction Act promise well for future legislation, and I hope to see the spirit of that legislation carried over vividly and efficaciously into this National Health Act of 1947.

I would like to ask you, Father, whether or not you concur with the statement which is set forth in the mimeographed statement of Mr. John H. Hayes, who testified earlier this morning, reading as follows:

> Passage of that act, Public Law 725—

which, I may say, is the Hill-Burton Act—

> by the Congress last year has already stimulated practically every State and Territory to make a survey of the hospital facilities and needs. The program of hospital building is already well along in the planning states, and there is now assurance that there will be additional hospitals in those areas where our citizens will best be able to use them.

Father SCHWITALLA. John Hayes and I are of one heart and one mind on this matter, Senator.

Senator DONNELL. You concur generally with that statement made by Mr. Hayes?

Father SCHWITALLA. Yes, sir.

Senator DONNELL. I take it, Father, that it would not be practicable nor advisable to undertake to construct every hospital all over the United States at once. You would have problems of providing personnel, as well as the great difficulty of carrying on such a huge construction program at once, as well as losing perhaps the value of some little degree of experimentation in the buildings that are put up from time to time. Am I not correct in that?

Father SCHWITALLA. Despite the statement by Senator Pepper I think this is another step, and that is all I want to say about it.

Senator DONNELL. You regard S. 545 as another forward step? You regard the Hill-Burton Act as having already provided for the preliminary phases of this program?

Father SCHWITALLA. Yes, sir.

Senator DONNELL. Now, one other matter, Father. You referred to section 2(c), and I greatly appreciate your comment on that section, which appears at page 2 of the bill, namely, in setting forth the findings of the declaration of Congress that it is the policy of the United States to aid the States through consultative services and grants-in-aid to make available medical, hospital, dental, and public-health services to every individual, regardless of race or economic status. And you state this in closing your testimony:

> If this statement of objectives is to be taken seriously, it certainly lays down a long-range program for the attainment of which this bill makes significant

but only partial provisions. Personally I would seriously question the feasibility of the purpose proposed in such a statement.

I would like to say in that connection, that, speaking for myself at any rate, we do not have in mind the idea of the Federal Government itself providing medical, hospital, dental, and public-health services to every individual regardless of race or economic status. As I see it, the thought behind the bill is that, as stated in 2 (c), it is the policy of the United States to aid the States, and does not mean either that the bill envisages an idea that the States are going to have a general health service for every individual, but rather that it shall provide the filling of the space which is not covered by the use of private funds and private initiative, through application of State and Federal funds for the benefit of those who need the services that are not provided by private enterprise and by institutions such as those for which you gentlemen have spoken this morning. I wanted to make that clear.

Father SCHWITALLA. You have said that so much better than I said it in my paper, but that is the understanding I have, too.

Senator DONNELL. We appreciate very much your comments, and I want to thank you not alone for your very exhaustive study of this matter and presentation of it, but particularly for your practical suggestions to us. We are very grateful to you for coming.

Our next witness is Dr. John G. Martin, superintendent of the Hospital of St. Barnabas for Women and Children, Newark, N. J.

## STATEMENT OF THE REVEREND JOHN G. MARTIN, S. T. D., SUPERINTENDENT, HOSPITAL OF ST. BARNABAS AND FOR WOMEN AND CHILDREN, NEWARK, N. J.

Dr. MARTIN. Mr. Chairman, I would like to note that I am accompanied by Rev. Chester C. Marshall, vice president of the American Child Hospital Association.

Senator DONNELL. We are very happy to have both of you present; and if you will proceed with your statement, Dr. Martin—I am going to ask you that you first give us a brief statement of your background and experience along the lines embraced in the general testimony here this morning.

Dr. MARTIN. Yes; I will give you that, Mr. Chairman. My name is John G. Martin, a clergyman of the Episcopal Church. I am a past president of the American Protestant Hospital Association, which I have the honor to represent at this hearing. I am also a past president of the New Jersey Hospital Association and now a member of its board of trustees, a member of the board of trustees of the Hospital Service Plan of New Jersey, and a member of the board of trustees of the Hospital Council of New Jersey.

Senator DONNELL. Dr. Martin, I would like to interrupt your testimony to state that Senator Smith, who is chairman of this subcommittee, is one of the Senators from the State of New Jersey, and I am sure regrets exceedingly his inability to be here during your testimony and the remaining testimony this morning. Senator Smith was here and conducted the opening portion of the meeting, but he has another extremely important committee duty this morning which necessitated his absence. He is most faithful to this committee, and, not only from his interest in the subject but from the fact that you gentlemen hail from the same State, I am sure he would be greatly delighted to be here; and I will call attention to the fact that his administrative assistant, Mr. Stewart, is here this morning, and I am sure will undertake to relate to Senator Smith as best he can the general nature of your testimony and, in addition, hand him a copy of it as presented here.

Now, will you proceed, Doctor?

Dr. MARTIN. I am superintendent of the Hospital of St. Barnabas and for Women and Children, of Newark, N. J., serving my twenty-fourth year in that capacity.

Members of the American Protestant Hospital Association are greatly interested in the bill S. 545 for it deals with subjects that have become serious problems for them.

The New Jersey Hospital Association, at its twenty-third annual convention, passed the following resolution on May 16, 1947:

> Whereas bill No. 545 introduced in the United States Senate on February 10, 1947, by Senators Taft, Smith, of New Jersey, Ball, and Donnell, and popularly known as the National Health Act of 1947 has as its purposes the creating of a national health agency, the granting of additional funds to the United States Public Health Service for the prevention and control of cancer, the providing of medical and hospital services for low income families and individuals, periodic health examinations for school children, dental health services for school children, and low income families and individuals, the establishing of a national institute of dental research, and the permitting of pay-roll deductions for Federal employees who wish to participate in any voluntary nonprofit health insurance fund.
>
> And whereas these purposes and objectives are in the public interest and in the interest of hospitals: Be it
>
> *Resolved*, That the New Jersey Hospital Association, in convention assembled, endorse the principle of this bill; And be it further
>
> *Resolved*, That this endorsement be conveyed to the New Jersey Members of the United States Senate and House of Representatives with the request that each of them support its passage in their respective Houses.

The creation of a National Health Agency, wherein the most important Federal health activities may be brought into a coordinated central direction, is simply good organization. It should result in the elimination of discrepancies and conflicting decisions which are rendered by independent and unrelated authorities.

The addition of departments of medical and hospital care services and of dental care services as proposed in the bill should provide a solution to difficulties which have become unwieldy burdens for many hospitals.

Cancer is one of the chief causes of death and the allotment of additional funds to the United States Public Health Service for its prevention and control is a forward-looking step. This dread disease is no respecter of persons and attacks persons of all ages regardless of their economic status. Patients suffering from cancer come to our hospitals for the alleviation of pain and the comforts which may be given to incurable conditions and which often extend over long periods of time. They are not all hopeless. Many incipient cases are permanently cured by means of X-ray, radium, and surgery. Hospitals are in a position to lend valuable assistance in a program designed to attack this problem vigorously.

The survey of medical, surgical, and hospital care should undoubtedly bring to light a need for governmental support of health programs in behalf of the indigent members of society. It is a wise provision to study the field of operations for the purpose of determining proper courses of action for relief of those who need this care.

The provision of medical care services in homes and hospitals for families and individuals with low income is a function that rightly belongs to the Government. Our hospitals have carried the burden willingly for the past century. Indeed many of our church hospitals came into existence primarily for the purpose of furnishing medical aid to those who cannot afford to pay for it. There is no desire to diminish this service and the hospitals welcome the opportunity to exercise their beneficent aid to the full extent of their ability. In several instances, particularly of our older church hospitals, large endowments have been erected by reason of gifts and legacies of philanthropically minded citizens. The income from these trust funds has served the poor well. However, the greatly increased cost of living has had the result of reducing the effectiveness of endowment funds. Interest returns are lower than formerly. Their income will purchase only about one-third of the service and material that were formerly provided and needed for this work. Costs of commodities and professional service and labor have risen to unprecedented heights so that funds that were formerly adequate are now insufficient to pay for the requirements of service to the underprivileged members of society. But many hospitals have little or no endowment funds. They are without the means of extending their services to the indigent except by charging paying patients rates high enough to assist in financing the care of the poor, or by securing contributions for that purpose. It is manifestly unfair to lay the burden of the indigent load upon the shoulders of other paying patients.

The problem has become extremely serious in view of the tremendous increase in the costs of sickness and hospitalization. Even the institutions that were well endowed are now embarrassed by the limitations they are forced to effect in their accustomed service to the poor.

The question which faces many boards of trustees is how to finance service to the indigent. Eleemosynary institutions are experiencing serious deficits and appeals to cover deficits are very unglamorous. The inference is that there has been poor management for an institution to have fallen into such a predicament as to have a deficit. The criticism of such philanthropic efforts on the part of business authorities is that an institution should live within its means and not incur deficits. To follow this principle faithfully would mean that many worthy applicants for medical, surgical, and hospital service would be turned away without relief. Such practice is contrary to the spirit of the service which is reflected in the hearts, minds, and wills of the American people.

Therefore, if endowment funds are inadequate, and such is undoubtedly the case today, additional means of providing financial aid are necessary. Community Chest funds have stepped into the breach and they have financed this work in many localities. But recent experience has shown that in most cases the income from these sources is inadequate to the need. The way to broaden the base of support is by Government participation in providing the funds.

The importance which New Jersey attaches to the subject of hospital care for the indigent is shown in a pamphlet entitled "Hospital Care of the Indigent and Medically Indigent in New Jersey," prepared in 1945 by the welfare committee of the New Jersey Hospital Association in cooperation with the division of statistics and research of the New Jersey Department of Institutions and Agencies. This pamphlet is presented to you in full, and I quote briefly from it:

*II. General Principles Relating to the Determination of Financial Responsibility*

The principle that poverty shall not deprive people of hospital care is implicit in the New Jersey Statutes, as indicated by the very comprehensive legislative program for the support by local government of charitable hospitals, described later in this pamphlet.

Difficulties have been encountered, however, in the interpretation of some of these statutory provisions, especially with reference to the degree of public responsibility to pay for the hospital care of persons who are self-sustaining except for their inability to finance the cost of hospital service.

The welfare committee has therefore undertaken to formulate general principles which it is believed may be helpful in resolving both the legal questions which have arisen as well as the philosophic questions which underlie them.

The welfare committee accepts in principle the definition arrived at in 1936 by the joint committee of the American Public Welfare Association and the American Hospital Association recognizing two classes of indigent patients:

"Persons entitled to necessary medical care (are) to include those persons whom the public authorities have under their care and those persons who are otherwise able to maintain themselves but who are unable to secure necessary medical care out of their own resources."

In any program designed to utilize tax funds for financing the care of the indigent sick in voluntary charitable hospitals, observation of the following basis principles is recommended:

1. The determination of medical need is a medical responsibility.
2. The determination of eligibility for care at public expense should be the responsibility of the governmental agency which authorizes the expenditures in accordance with established standards of eligibility agreed upon by hospitals and welfare officials.
3. Persons already accepted for maintenance at public expense should be eligible, without further investigation, for hospital care at public expense.
4. For the otherwise self-supporting, decision concerning financial eligibility for care at public expense should be reached by authorized officials after proper and adequate investigation, which should consider possibilities of payment from post-hospital earnings.
5. Hospital care at public expense should be authorized on an individual case basis by the governmental agency responsible for payment.

Mutual understanding and cooperation between hospitals and public authorities is an important element in the formulation of plans for financing the cost of hospital care of the indigent and medically indigent.

The joint committee of the American Public Welfare Association outlines six principles relating to this phase of collaboration between governmental and nongovernmental hospitals as follows:

"Public officials should recognize that good hospital service is increasingly complex and costly; that a high standard of care of patients is important and an ultimate economy, and they should appreciate the close relation of hospital service to general medical practice and to public health.

"Public authorities should bear in mind that needy persons are entitled to a high standard of care and that per diem rates must be high enough to permit this type of service.

"Public authorities should recognize that hospitals cannot assume the responsibility of caring for public patients if the finances paid by them for that care are too small to enable the hospital to maintain a satisfactory financial status."

A review of the existing legislation in New Jersey with regard to the hospital care of the indigent and medically indigent reveals that legal basis exists to provide adequate medical and hospital care for sick persons, without regard to their ability to pay for the services they need. These laws appear to lay the foundation of a program of hospital care fully meeting the principles laid down by the joint committee. The feeling exists, however, that for one reason or another they are not being completely utilized either by the hospitals or by the communities.

The basis of uncertainty is ascribed to unfamiliarity with the laws and to the varying types of working agreements which individual hospitals had been able to work out with the communities they serve, having the effect of making both the extent and the manner of meeting the costs of hospital care for the indigent sick unequal and uncertain.

The legislative provisions on the New Jersey statute books fall under four main types:

A. Payment on a per diem basis for the care of individual patients certified as indigent by the local public assistance agencies.

B. Appropriations fixed in amount without direct reference to the volume of aid to the indigent sick made by municipalities to the hospitals in recognition of care furnished to the indigent sick.

C. Payments made by counties based upon an annual appropriation divided among the voluntary charitable hospitals in accordance with the percentage distribution of "free" service rendered by the several hospitals qualifying for aid under this legislation.

D. Payments on a per diem basis for the care of individual patients certified as indigent by agencies charged with the care of certain categories of indigent persons—the aged, dependent children, crippled children, and so forth.

Federal legislation affects the financing of hospital care for the indigent sick in a variety of ways.

Categorical relief programs for the care of the aged, dependent children and the needy blind receive one-half of the funds expended, up to specified maxima, from the Federal Government under the Social Security Act. This act contemplates that payments will be made directly to the recipient and has been drafted in such a way as to require that allowances be paid in cash or warrant directly to the beneficiary. In spite of this requirement, it is sometimes possible for State and local agencies to make payments to hospitals on behalf of individuals whose primary assistance grants are financed in part by Federal funds through the device of using State and Federal funds for the amount of grants in excess of Federal limitations. The administrative procedures in such cases are necessarily complicated.

Under the same act, however, the Crippled Children Commission received a major proportion of its funds and this agency is permitted to utilize its Federal money to pay hospitals for services rendered to physically handicapped children designed to correct or to alleviate the disabling condition.

The Rehabilitation Commission also receives a Federal subsidy through the Social Security Act which provides some of the moneys used in the vocational rehabilitation of physically handicapped adults.

To a certain degree, therefore, all forms of categorical assistance previously discussed are influenced by Federal legislation as well as by State legislation.

The Federal Government also subsidizes certain wartime health programs which may involve the payment of voluntary charitable and other community hospitals for the care of individual patients. The two programs now operative in New Jersey are the emergency maternal and infant care program, and the venereal disease program, administered respectively by the maternal and child health division and the bureau of venereal disease control of the New Jersey State Department of Health.

We are pleased with the limitation provided in S. 545 of aid to families and individuals of low income and that there is no compulsion with regard to persons who are able to pay their way. The voluntary hospital system has been developed to a high proficiency and should be encouraged. Good business practice is sufficient reason for the provision in the bill for collection of proper charges from those able to pay part or all the cost of care. When hospitals make these collections and funds become available from the Government, Federal and State, for the care of the indigent, it would seem that the financial problems of the care of patients in hospitals would be solved.

There is general approval of the provision for making grants-in-aid to the States with the requirement that the States bear their rightful share of expense for care of their indigent citizens. This is better than a centralized Federal control of all health activities. Control of such service is better placed at the local level with responsibility for its administration resting upon local officials.

Other features of this bill are commendable, such as the extension of health services to include physical examinations for all children in elementary and secondary schools and also provision for dental service and research.

It is our hope that this bill may be promptly enacted and that the States will follow through for the early implementing of plans to improve the health of the Nation.

Senator Donnell. Senator Pepper, would you like to ask Reverend Martin some questions?

Senator Pepper. Yes. Reverend Martin, I was attracted to one of your statements, I believe on page 6, wherein you said that—

> any program designed to utilize tax funds for financing the care of the indigent sick in voluntary charitable hospitals, observation of the following basic principles is recommended.

Then your second principle is:

> The determination of eligibility for care at public expense should be the responsibility of the governmental agency which authorizes the expenditures in accordance with established standards of eligibility agreed upon by hospitals and welfare officials.

As applied to the Taft bill, would that mean the Federal Government, which is one of the contributors to the fund, would also lay down the standards or would have to approve the standards of eligibility?

Dr. Martin. I would say that that would be a State obligation, to decide upon the eligibility within the State. That is a quotation from the principles recommended by the American Public Welfare Association.

Senator Pepper. So you think the Federal Government should make the contribution that the bill contemplates, but should not have anything to do with the standards of eligibility which the States may prescribe?

Dr. Martin. No; I would not say that. I would think that the over-all general policies of the entire program should be the responsibility of the Federal Government in guiding the State governments in the implementing of the law.

Senator Pepper. But naturally, we have conditions that are somewhat comparable all over the country, and would you say, therefore, that the Federal Government should have either to lay down or approve the standards of eligibility of the several States?

Dr. Martin. I think certain general policies should be applicable to the entire Nation. They should be formulated by the Federal Advisory Board, or whatever council is set up, or the Administrator.

Senator Pepper. You mean policies as to administration as distinguished from standards of eligibility?

Dr. Martin. I should think that would be correct; yes.

Senator Pepper. The reason I asked that question, Doctor, I think that is the very heart and core of this bill, and from my point of view is its principal defect. Do you regard the bill as requiring a means test for eligibility?

Dr. Martin. The means test is something that is implemented at the local level by the investigators.

Senator **Pepper**. But the bill does, though, contemplate a system of medical care which contemplates a means test, so it is a means test bill. Now then, do you apprehend any difficulty on the part of the States even, supposing they laid down the standards of eligibility in meeting your standard here:

> The determination of eligibility for care at public expense should be the responsibility of the governmental agency which authorizes expenditures in accordance with established standards of eligibility agreed upon by hospitals and welfare officials.

Now, can you suggest what would be a desirable standard of eligibility under this bill?

Dr. **Martin**. Yes. The State of New Jersey already has a system of standards which is used in its allocation of aid to indigent in New Jersey. For New Jersey they are adequate. I should think that other States would formulate standards that would be adequate for those States.

Senator **Pepper**. Do those standards determine the medically indigent as well as the actually indigent?

Dr. **Martin**. It is my understanding they do, medical and actual.

Senator **Pepper**. Could you tell us what those criteria are?

Dr. **Martin**. They are outlined here in this pamphlet.

Senator **Pepper**. You mean outlined in your statement?

Dr. **Martin**. No; in the quotations from this pamphlet, from "Hospital Care of the Indigent and Medically Indigent in New Jersey."

Senator **Pepper**. What I was getting at, Dr. Martin, is the difficulty of determining in a given community who shall be the recipient of this aid. Suppose you have a woman, for example, who does domestic work. She has $50 saved up. She is overtaken with illness. She has that $50 in the bank. Shall she pay at first all the money she has in the bank to the hospital and to the doctors?

Take another case of a man making $150 a month, who has a wife and, we will say, three children. He has $500 worth of Government bonds. That is all he has. And his salary is such that he is only able to pay $5 or $10 a month out of his salary. That is one case.

Take another case of a man who is making $4,000 or $5,000 a year, but he has had a lot of sickness and expense in his family, and maybe he is already in debt to the bank for $1,500 or $2,000 for assistance received—what are you going to do in the case of that fellow?

Take another man that does not have any money in the bank or any property at all, but his credit is good in the community. He could go to the bank and borrow $500 to pay the hospital.

So you have all kinds of situations. Now, the principal difficulty of the means test is, first, embarrassment of the ordinary person in going up and admitting inability to pay, and asking, therefore, for public charity, because under this bill he contributes nothing; he pays into no fund. You have a psychological barrier in the first place, and, in the second place, you have what seems to me an almost insuperable difficulty in pulling down general standards, and I say that here there should be a general standard that everybody recognizes—you have difficulty in laying down a general standard that will be fair to everybody and will adequately and properly define the medically indigent as well as the actually indigent.

Dr. MARTIN. I will say, Senator, that while it is complicated, very complicated, it is not insuperably so. Referring to the actual conditions in the hospitals that we operate, we have social-service investigators, financial investigators, who review the applications of patients who desire hospital care and who request financial assistance. The social-service investigators very carefully and privately interview the applicants and ascertain from them and from supporting statements, which they investigate, what their actual financial status is—those very things you have mentioned, such as their bank standing, their standing in the community with regard to insurance, hospitalization insurance, medical-care insurance, the number of persons in the family, the income from each member in the family to the family income, the rent that the person pays, the amount of expenses in the family. All of those things are gone into very carefully, and in that way standards have been set up among social workers in hospitals, and they are utilized rather generally in hospitals for the determination of what is a fair amount that the individual should pay, or whether the patient should be given free care, that is, care without payment by the individual.

Senator PEPPER. But does that meet your criteria here:

> The determination of eligibility for care at public expense should be the responsibility of the governmental agency which authorized the expenditures in accordance with established standards of eligibility agreed upon by hospitals and welfare officials.

Are you going to leave it to just a group of social workers? In one community you might find one standard observed; in another community, another standard; in one State one group of standards, in another State another group. You are not going to require and publish to the public so all will know it, some general standard of eligibility?

Dr. MARTIN. No, Senator, just what this says, there should be established standards of eligibility "agreed upon by hospitals and welfare officials."

In other words, these same principles that I have outlined, established by the individual hospitals for their social workers, could be enlarged, and through cooperation with State officials and groups of hospital officials, the same standards or similar adequate standards could be formulated for the entire State.

Senator PEPPER. And published so that the people could all see it?

Dr. MARTIN. Could be published, yes.

Senator PEPPER. Did you notice the declaration of purpose or objective in the original part of this bill, page 2:

> (c) That it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status.

Do you think the $200,000,000 appropriation contemplated in this bill will achieve that policy?

Dr. MARTIN. That is something that must be experienced. This whole bill is a step in the direction of providing adequate care for the people of the Nation, and I don't think there is anybody in the Nation that can answer that question "yes" or "no," whether it is adequate or not.

Senator PEPPER. Do you think, in order to provide adequate care in this country, we should have more doctors, technicians, and nurses?

Dr. Martin. In order to man additional hospitals and health centers it would be necessary to have additional doctors and nurses educated for that purpose.

Senator Pepper. Do you favor any public assistance or any public program, especially Federal, program for Federal assistance, in the direction of providing for more doctors and technicians and nurses for the country?

Dr. Martin. Some educational programs, with the support of the Government, I should think would be very vital.

Senator Pepper. You do not find any such provision in this bill, do you, except with respect to possible assistance under the general research part of the bill, to dentists?

Dr. Martin. Not in the education of doctors and nurses.

Senator Pepper. So you do not find any provision in this bill which is aimed at the provision for more doctors and technicians and nurses.

Just one other question. Do you feel that the appropriations contained in this bill will meet the need for medical care of the people of this country?

Dr. Martin. What was the question, Senator?

Senator Pepper. Do you feel that the appropriations provided for, or contemplated by this bill, will, together with the funds that the States will put up, provide the needed medical care for the people of this country?

Dr. Martin. I don't think it will be complete, but it will be greatly improved over what we have now. The great need for the care of the indigent will be improved, and the supplying care to the indigent will be improved by the implementing of this bill, by utilizing the existing hospitals which are already taking care of the indigent, and which are experiencing large deficits largely because of that condition.

Senator Pepper. Doctor, we all agree that there is great need of the hospitals of the country for help, and we all appreciate the magnificent job they have been doing and are doing under great difficulties. Now, is it your experience that part of the most severe need for medical care in the country is in what we might call the white-collar group, the middle-class group of the country, which is not willing to accept charity and doesn't have the money to pay for the needed medical care?

Dr. Martin. It is a great burden upon the so-called white-collar class at the present time that are not organized, and therefore have not had the advantages of large group increases in their remuneration.

Senator Pepper. Do you think this bill is likely to give great assistance to that class of our people?

Dr. Martin. If they are medically indigent or actually indigent, it would help them.

Senator Pepper. Do you know whether the authors of this bill have made any study as to how many people there are who are indigent in the country and how many medically indigent, and whether they have, by any kind of calculation, arrived at this $200,000,000 appropriation?

Dr. Martin. The bill provides for an extensive investigation and study of those conditions to determine what the needs will be, and upon the determination of the need, further implementing of the bill will be available.

Senator PEPPER. Are you opposed to the principle of insurance, compulsory insurance, for medical care?

Dr. MARTIN. Yes. I believe that the voluntary system is better for the people of this country than compulsory health insurance.

Senator PEPPER. Do you believe the voluntary system will give coverage to as many people as the compulsory system would?

Dr. MARTIN. For hospital service, you mean?

Senator PEPPER. For medical care.

Dr. MARTIN. Just a year ago, Senator, on the 6th of May I appeared before this committee and you asked me a similar question. You asked me how long would it take for the Blue Cross plan to adequately cover the needs of the people of this country. A previous speaker had said 50 years. I said 10 years. That was just 1 year ago, and at that time we had 21,000,000 persons in our Blue Cross Plan. Today we have 25,000,000. Now there is an increase of 4,000,000 in 1 year, and with that momentum and that increase going on year after year, I still think that my estimate of 10 years is not far from accurate.

Senator PEPPER. The Blue Cross Plan does not give comprehensive coverage to those that are included; does it?

Dr. MARTIN. No; but there are accompanying medical service plans that are akin to the hospital plan, Blue Cross Plans, and they are also making very fine progress in the country.

Senator PEPPER. Does your information coincide with mine, that only about 2½ percent of the people of the country are covered with any comprehensive coverage by voluntary insurance plans?

Dr. MARTIN. I think it is more like 20 percent.

Senator PEPPER. It is just a question of fact. Our committee made quite a study of the subject for some years, and our conclusion was that about 2½ percent of the people of the country are covered comprehensively by any voluntary insurance plan at the present time.

Dr. MARTIN. By "comprehensively" you mean insurance of all cases—health insurance?

Senator PEPPER. Correct.

Dr. MARTIN. But still, that can be improved. Ten years ago that same figure applied to the hospitalization at that time, but under the Blue Cross Plan today it has risen from 2 to 20 percent, and there is no reason why a voluntary plan with Federal aid and support, which has been lacking up to the present time, might not do very well.

Senator PEPPER. Has your association constantly insisted to the Congress that it should make adequate funds available for hospital construction and should also try to make funds available in a proper way for the education of doctors and technicians and nurses in the country?

Dr. MARTIN. I am not so sure that the Federal Government should go into the matter of the problem of providing all that education—higher education. There are a large number of very fine universities giving excellent courses, and they are taking care of the higher education very well, I think.

Senator PEPPER. You do not mean by that that there are enough doctors in the country, Reverend Martin?

Dr. MARTIN. That there are enough doctors?

Senator PEPPER. Yes.

Dr. MARTIN. I don't know whether there are enough doctors in the country for all the needs. I should think, though, that there would be need for an additional number of doctors with the additional hospitals to be erected.

Senator PEPPER. Have you any proposal of a method by which we might get the required number of doctors?

Dr. MARTIN. Yes; increase the number of students in the existing universities.

Senator PEPPER. Is any public assistance needed to increase the number of students, in your opinion?

Dr. MARTIN. I think the universities would be the ones to answer that question—whether they need the assistance or not.

Senator PEPPER. I ask those questions because this always interests me—that so many of you gentlemen appear here who have had hospital experience; you know what the financial needs of the hospitals are; you know the number of people who cannot afford the hospitals; you should know the inadequacy of the number of doctors and technicians of one sort and another in the country. I have been for several years a member of this committee, and I have many recollections of informed people coming before the committees of Congress and saying, for example, a case like this:

> The Taft bill will do $200,000,000 worth of good. It is something better than we have got, but, gentlemen, I want to tell you about the inadequacy of what is proposed compared to the need. I want to tell you what the hospitals of this country are struggling under and how many hospitals this country needs, and how terribly important it is for you to help the country get them. I want to tell you how many doctors we need, how many technicians we need, how many nurses we need—

and they appeal to Congress to set in motion plans and programs to help a country to have those doctors and technicians and nurses, and upbraid us for our inadequacy, and I have always been a bit disappointed that you gentlemen who should have so much knowledge of the subject are willing to accept so little.

Dr. MARTIN. There is a provision in this bill for investigation of just those things, and I think that investigation should bring out the need.

Senator PEPPER. Thank you, Doctor.

Senator DONNELL. Reverend Martin, Senator Pepper has referred to the great experience that you gentlemen have had, and expresses disappointment at your not concurring with some of the hopes and views that he has had and espoused. I take it that, in view of the experience you have had as the former president of the American Protestant Hospital Association, and otherwise professionally, you have come to the conclusion that this compulsory health-insurance plan is not the solution of the problem. Is that correct?

Dr. MARTIN. That is correct.

Senator DONNELL. I want now to refer to the difficulties that the Senator has emphasized with respect to ascertaining whether or not the person does have insufficient income to pay the whole cost of hospital services, surgical services, medical services, and so forth. I understood you, Reverend Martin, to indicate that you recognized the difficulties, but that these difficulties were being solved. That is correct, is it not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. It requires investigation and study, and those investigations and studies have produced solutions, practically, of these very difficult problems to which the Senator has so completely referred. Is that correct?

Dr. MARTIN. Yes, sir.

Senator DONNELL. Now, may I refresh your memory, if it needs refreshing at all, on the provisions of the Social Security Act. You are familiar generally with the Social Security Act, which is in operation throughout the Nation; are you not?

Dr. MARTIN. Generally; yes.

Senator DONNELL. And you are familiar, I take it, generally speaking, with the fact that the opening section of that act says:

> For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such States, to aged, needy individuals there is hereby authorized to be appropriated—

and so forth.

You are familiar also, are you not, with the fact that the Federal law does not in any sense undertake to define what are needy individuals?

Dr. MARTIN. That is done at the local level.

Senator DONNELL. That is done at the local level, and that is what you propose to have done under the Taft bill, S. 545? That is correct; is it not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. And you know, do you not, as a matter of general knowledge, that the State of New Jersey, my own State of Missouri, and other States define as best they can what is the meaning of the term "needy individuals," and that they have found it possible to do so and administer vast sums of Federal and State moneys in reliance upon the determination made at the local level? That is correct; is it not?

Dr. MARTIN. That is correct.

Senator DONNELL. Dr. Martin, do you regard it as desirable that the Federal Government undertake to lay down some general definition for all parts of the country without regard to local conditions or what constitutes the need of individuals, or do you think it is better to leave that to the local States to determine who are needy individuals, just as we are now doing?

Dr. MARTIN. I think it is better for the standards to be set up at the local level, and the policies of distribution of money at the individual level.

Senator DONNELL. There are quite different circumstances in New Jersey and in Wyoming, for illustration, and even between Florida and Maine, are there not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. So that there are different conditions which make it advisable for localities themselves—for the States themselves, as distinguished from the Federal Government—to undertake to define what constitutes need or what constitutes insufficiency of income within their own borders. That is correct, is it not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. You favor having that done by the local authorities—that is to say, the State authorities, or even sublocal authorities designated by the States—rather than by the Federal Government here in Washington?

Dr. Martin. Yes, sir.

Senator Donnell. Emphasis has been laid here by the Senator upon one provision in the opening portion of this bill, section 2 (c), which says:

> That it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status.

I call your attention, Reverend Martin, to the fact that there is nothing in that sentence that in the slightest even remotely implies that the purpose of this bill is to provide all the funds necessary to give everybody in the United States medical, hospital, dental, and public-health services. You have not understood the bill to mean that at all, have you?

Dr. Martin. No, sir.

Senator Donnell. In other words, this bill undertakes, does it not, to provide ancillary, supplementary funds to supplement what private hospitals, Catholic institutions, Protestant institutions, locally financed operations, State operations are now doing in an attempt to provide at least a start toward filling in that gap and thus making it possible by the use of existing facilities, plus this additional supplementary item, to provide adequate treatment for every individual. That is the purpose of this bill as you understand it, is it not?

Dr. Martin. Yes, sir.

Senator Donnell. You do not understand that it is the purpose of this bill to dole out Federal money to everybody in the United States that comes up saying he needs medical, hospital, dental, or public-health service?

Dr. Martin. No, sir.

Senator Donnell. Of course, $200,000,000 would not be a start on that; in fact, it gets up into the billions of dollars, does it not, if that sort of plan were to be promulgated?

Dr. Martin. Yes, sir.

Senator Donnell. And, as a matter of fact, you appeared before the Education and Labor Committee last year, did you not?

Dr. Martin. Yes, sir.

Senator Donnell. And is it not a fact, Reverend Martin, that your observation is that in order to carry out the plans of the compulsory-insurance proponents, as outlined in S. 1606 last year and S. 1320 this year, it would require many billions of dollars of Federal funds taken out of the Federal Treasury to do that? That is correct, is it not?

Dr. Martin. Yes, sir.

Senator Donnell. Now, another point that was emphasized by the Senator in his interrogation was what he termed the absence of any provision in this act, S. 545, with respect to the training of personnel. Do you have a copy of that act before you, Doctor?

Dr. Martin. Yes, sir.

Senator Donnell. I wonder if you would turn to page 13, for instance. There is an amendment proposed to the Public Health Service Act, and it enables the Surgeon General, quoting from this bill, S. 545:

> To enable the Surgeon General to carry out the purpose of section 301 with respect to developing more effective measures for the prevention and control of cancer, and to assist, through grants and as otherwise provided in this section,

States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention and control of such disease, including the provision of appropriate facilities for diagnosis, and including the training of personnel for State and local health work.

You observe that language in this bill, do you not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. And, of course, that relates, as I have indicated there, to the control of cancer. That is an amendment to the Public Health Service Act, is it not, as you will observe at the bottom of page 12?

Dr. MARTIN. Yes, sir.

Senator DONNELL. Now, Doctor, I want to call to your attention the fact that the well-established policy under the Public Health Service Act is to do likewise as to each specific program. For instance, section 314 (a) of Public Law 410, which is the Public Health Service Act now in effect, reads at the outset as follows:

> To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of venereal diseases, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such diseases, including the training of personnel for State and local health work—

and so forth.

Now I call your attention to the succeeding subsection (b), which relates to the matter of tuberculosis, and in substantially the same language, perhaps identically the same, concluding with this language:

> including the provision of appropriate facilities for care and treatment, and including the training of personnel for State and local health work.

Then I call to your attention subsection (c), page 13, at the bottom, and the top of page 14, Public Law 410, which is a general provision to enable the Surgeon General to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States, in establishing and maintaining adequate health public services, including grants for demonstration and for the training of personnel for State and local health work, "there is hereby authorized to be appropriated for each fiscal year a sum not to exceed $20,000,000."

So, Reverend Martin, the fact is that in this specific instance here in which cancer is taken up and provision is made in S. 545 for the training of personnel, this is just a following out of the general course of procedure under the Public Health Service Act as I have indicated. That is correct, is it not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. Now, I want to ask you just one or two questions—I will say to Senator Pepper that permission has been obtained for our subcommittee to continue in session. We have a law now which might take Senator Pepper here permanently out of this committee, and me, too, if we should undertake to stay in session here while the Senate is in session, but leave has been granted to us to continue this session.

Now, Reverend Martin, I wanted to ask you one or two other things. You refer to being a past president of the American Protestant Hospital Association, which you state you have the honor to represent at this hearing. Would you tell us, please, what is the American Protestant Hospital Association for which you appear here?

Dr. MARTIN. It is an association of hospitals of the United States and Canada, that have in general Protestant Church management and community management, not necessarily church management. As you know, there are three associations and ours is similar to the Catholic Hospital Association, except not so large. We have about 300 or so members—I don't remember the exact number—in the Protestant Hospital Association.

Senator DONNELL. Scattered all over the United States?

Dr. MARTIN. Scattered all over the United States.

Senator DONNELL. Now there is the New Jersey Hospital Association of which you are a past president; the Protestant Hospital Association of which you are a past president; then there is the Catholic Hospital Association of which Father Schwitalla is president—and I am referring to Father Schwitalla who testified here this morning—then there is the American Hospital Association of which Mr. Hayes, who testified this morning, is president. That is correct, is it not?

Dr. MARTIN. That is correct.

Senator DONNELL. You refer also to being past president of the New Jersey Hospital Association, a member of the board of trustees and a member of the board of trustees of the Hospital Service Plan of New Jersey and the Hospital Council of New Jersey. Would you tell us, please, something of the New Jersey Hospital Association? How large an organization is that?

Dr. MARTIN. That is an organization of about 80 institutions in the States, both voluntary and governmental. In addition to that, there are about 500 individual members. It started in about 1924 or 1925 and has been an organization of voluntary membership, and this last year it has increased its work to such an extent that it has engaged a full-time executive secretary.

Senator DONNELL. The New Jersey Hospital Association, as you have testified, holds annual conventions, and held its twenty-third convention just 12 days ago?

Dr. MARTIN. That is right.

Senator DONNELL. By the way, you are from Newark, are you not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. And Newark is the largest city in New Jersey, is it not?

Dr. MARTIN. Yes, sir.

Senator DONNELL. And I realize you may not want to comment on your own hospital, but I may state for the record that it is my understanding that the Hospital of Saint Barnabas for women and children, of which you are superintendent, is certainly one of the finest hospitals in New Jersey. You may not want to comment upon that, but I will put that into the record, and I think it is a fact.

Now, Reverend Martin, at the meeting held by the New Jersey Hospital Association on May 16 of this year you stated at the outset of your testimony that a resolution was passed which you read. Will you tell us, please, approximately how many institutions are members of the association and were represented at that meeting?

Dr. MARTIN. There is a registration of over 300, and the number of institutions represented, I do not have the exact number, but certainly is was between 50 and 60.

Senator DONNELL. I observe that the concluding sentence of that resolution, after referring to S. 545, says:

> *Be it resolved*, That the New Jersey Hospital Association, in convention assembled, endorse the principle of this bill; and be it further
>
> *Resolved*, That this endorsement be conveyed to the New Jersey Members of the United States Senate and House of Representatives, with the request that each of them support its passage in their respective Houses.

May I ask you, Doctor, whether or not you concur in the sentiment expressed in those sentences?

Dr. MARTIN. Yes, I do.

Senator DONNELL. That is all, Reverend Martin.

Senator PEPPER. Dr. Martin, may I ask you just a question or two? In the answer that you gave to the chairman respecting the aid for training of personnel, the demand for medical care, and the other sections of the public health statutes to which your attention was called, you did not mean that the present law or the provisions of this bill authorize Federal aid in the training of doctors and general technicians, did you, in the medical schools of the country?

Dr. MARTIN. In our hospitals we consider as personnel all the persons who are assisting in the work of the hospital, and doctors and nurses would be then part of the personnel.

Senator PEPPER. But the bill to which your attention was called, on page 13, relates to cancer.

Dr. MARTIN. Yes.

Senator PEPPER. And that would not cover physicians generally, would it?

Dr. MARTIN. Those who are working in cancer research, investigation and cure.

Senator PEPPER. But that would not cover the provision of aid to students that were attempting to become doctors, dealing in subjects other than cancer?

Dr. MARTIN. Not in this particular instance, no.

Senator PEPPER. And in the other sections which were called to your attention, they related to State and county health programs, did they not, not private doctors, not the training of private doctors by the Public Health Service? You do not maintain that the United States Public Health Service at the present time is providing medical training for students in medical schools to become private doctors, do you?

Dr. MARTIN. I don't know of any such cases.

Senator PEPPER. Are you familiar, Doctor, with the report of the medical economics section of the American Medical Association stating that families with incomes under $3,000 were unable to meet the cost of health and medical insurance?

Dr. MARTIN. I am not familiar with that report.

Senator DONNELL. Reverend Martin, do you know whether or not any of the grants under the Public Service Act are being now used for fellowships in medical schools?

Dr. MARTIN. I don't know that, Senator.

Senator DONNELL. You do know that the training of personnel for State and local health work includes the training of physicians and nurses? That is correct, is it not?

Dr. MARTIN. It could.

Senator DONNELL. It could be so interpreted, according to your knowledge?

Mr. MARTIN. Yes, sir.

Senator DONNELL. And may I call to your attention the fact that on page 11 of the Public Health Service Act the Surgeon General is authorized, in addition to the matter of the training of personnel, to make available research facilities and services for appropriate public authority, and to health officials and scientists engaged in special study, and to establish and maintain research fellowships in the service, with such stipends and allowances, including traveling and subsistence expenses, as he may deem necessary to procure the assistance of the most brilliant and promising research fellows from the United States and abroad, and to make grants-in-aid to universities, hospitals, laboratories, and other public or private institutions, and to individuals for such research projects as are recommended by the National Advisory Health Council, or, with respect to cancer, recommended by the National Advisory Cancer Council? Are you familiar with those provisions, generally speaking, of the National Public Health Service Act?

Dr. MARTIN. Yes, sir.

Senator PEPPER. I would like the record to show here, as it will show, the various sections of the Public Health Act which the chairman has read, but it is my understanding that the Public Health Service at the present time is not authorized by the act of Congress to provide funds to aid in the education of students seeking to be general private practitioners of medicine. Of course, that is a question of fact, but I just wanted the fact to appear—that observation to appear in the record.

Mr. Chairman, I am sorry that I had to leave before Father Schwitalla had finished his testimony and I would like to recall him for a few questions.

Senator DONNELL. We thank you very much, Dr. Martin.

Father Schwitalla, will you take the stand again for a few minutes?

## FURTHER STATEMENT OF FATHER ALPHONSE H. SCHWITALLA

Senator PEPPER. Father Schwitalla, I want to call your attention to the testimony of Rev. R. A. McGowan, director of the department of social action, National Catholic Welfare Conference, who testified before this committee on May 6, 1946, and in his testimony, after stating he came originally from the good State of Missouri——

Senator DONNELL (interposing). He said it was still his home.

Senator PEPPER. I am glad to know that. Father McGowan at page 1667 says:

> The social action department of the National Catholic Welfare Conference wishes to present a statement on the bill to provide a national health program, S. 1606. We wish to speak particularly on the part dealing with national health insurance.

Then he goes on and submits some observations. Then on page 1668 Father McGowan says:

> We favor the establishment of a national health program which will provide both hospital and medical care for the citizens of our country. We recognize that the voluntary systems of health insurance which have rendered excellent

service to our people would require some form of Government aid to achieve universal health security.

We favor in consequence a national system of insurance supplemented by Government tax revenues, by means of which all citizens can be protected in matters of health; but we consider that this bill as presently drafted is unsatisfactory because of the complicated methods of administration which it creates, and because of the excessive Government control over the health services which are to be provided. This statement is directed toward improvements in the bill.

But as I understand it, Father McGowan gave his approval to the insurance provisions of the bill.

Then on page 1671 the chairman, Senator Murray, asked Father McGowan this question:

Do you believe that a means test, making people dependent upon public charity, would detract in any manner from that dignity of the human personality?

Reverend McGowan. Yes, I think it would. Under this bill, which is quite extensive, that is not provided.

The Chairman. You think there should be some way of protecting that?

Reverend McGowan. Yes.

The Chairman. You think that any system which would provide for any section of our population to take a pauper's oath would not be in accordance with good, sound, Catholic thinking?

Reverend McGowan. Not for health purposes at all, no.

The Chairman. Has the church taken any stand during the past century, when these problems were being agitated in other parts of the country, with reference to systems of insurance, health insurance?

Reverend McGowan. I do not think there has been any formal statement, but there certainly has been great encouragement of the private health-insurance systems.

Then on the bishops' program on health insurance he says:

I made the statement in here, however, on the matter of advocacy of public health insurance by the bishops' program years back.

Then he goes on later on page 1672 and names the ones who participated in the bishops' program. The record then continues:

The Chairman. That contains this language:

"The social insurance provided in the Social Security Act is by no means perfect. To say nothing of other defects, it fails to provide for workers' insurance against sickness."

That is found on page 8.

Reverend McGowan. Page 8. That is the new introduction?

The Chairman. Yes. I believe that this document should be made a part of the record.

Pope Pius XI, in his encyclical on atheistic communism, dated March 19, 1937, gave his approval and encouragement to a system of insurance against illness, did he not, Father?

Reverend McGowan. Yes. In paragraph 52 of that encyclical he has something on it. I will read the whole sentence:

"But social justice cannot be said to have been satisfied as long as working men are denied a salary that will enable them to secure proper sustenance for themselves and for their families; as long as they are denied the opportunity of acquiring a modest fortune and forestalling the plague of universal pauperism; as long as they cannot make suitable provision through public or private insurance for old age, for periods of illness and unemployment."

On page 1821 of the same record Father O'Grady, representing the National Conference of Catholic Charities, says:

It is generally recognized today that in spite of the great advances that have been made by organized voluntary efforts and by local welfare agencies in providing medical and hospital care for the American people, we still have a large number of people who are not adequately protected. Our problem is to extend coverage without interfering with the gains that have already been made, as well as with the further gains that are bound to be made in the future by voluntary efforts of all kinds.

> Before entering into a discussion of the question of universal coverage against the hazard of ill-health, it would be well for us to keep in mind a few fundamental principles of social philosophy. In our society—in fact, in any society that is based on a clear understanding of the infinite worth of human personality—it must be assumed that our first objective must be to encourage the individual to provide health protection for his family through his own effort. It follows that we must also encourage the individual to enter into associations and organizations of his own choosing for the purpose of providing health protection for himself and his family. Government should encourage and promote such voluntary efforts on the part of the individual. It should not be to supplant the efforts of these organizations, for in doing so it would be striking at the very foundations of a democratic society. Government, therefore, has to proceed very carefully in the implementing of voluntary effort in the field of health protection.
>
> In providing more adequate health protection for the American people, we are confronted with certain fundamental ideological concepts. We have the concept of those who believe that a national health-security program should be confined to the so-called medically indigent; that those who need medical and hospital care might go to the local welfare agencies and submit to a needs test in order to secure it. This would place medical and hospital care in the same category as relief or public assistance.
>
> Those who would confine any public provision for medical and hospital care to the indigent sick believe that if local governments are unable to provide this care their efforts might well be implemented by assistance from the Federal Government.

Then he goes on to express doubt as to whether the American wage earner or the self-employed would be willing to submit to a needs test in order to secure medical and hospital care.

I wanted to call your attention to those statements to ask if you know whether those gentlemen still entertain the belief that was expressed on that occasion about this matter? Do you represent the organizations for which they purported to speak at that time?

Father SCHWITALLA. Mr. Senator, I have had a very delightful revival of my memory of that occasion. I think it was a very charming afternoon, and I feel very happy about everything that happened. The quotations that you have given us are quite partial, Senator Pepper.

Of course, you could not read all those papers, but remember there were some awfully interesting come-backs and interchanges of views between Senator Donnell and Father McGowan and others, and really I think if you want those read—I think the Senator will read them also. But while we cannot review that whole picture I do want to point out a few little things.

I cannot vouch for the National Catholic Welfare Council.

Secondly, I cannot vouch for the National Conference of Catholic Charities. There might be misconceptions there. Not every Catholic priest can talk for the Catholic church; not every Catholic priest can talk for his bishop. There is a limited opinion on essentials of details among the Catholic clergy, but the application of some of the principles are not necessarily matters of faith and morals, upon which there is a limit, and, therefore, in the application of basic principles and ethics and morals, Father McGowan, Monsignor O'Grady, and myself do differ and go to the mat in a very bloody fashion, if you don't mind my saying so, as we have done. So that one of the pet ways for Catholic priests to spend their time is in the logical interchange of ideas—sometimes very illogical. So I don't want to say for 1 minute that I have to agree with them or they with me. That is one point I want to make clear.

I want to say that the Catholic Hospital Association is one of the component associations of the department of social action of the National Catholic Welfare Conference, which department, in turn, is one of the largest divisions of the National Catholic Welfare Conference. Therefore, in general terms the opinions of the social action department, of which, by the way, Father McGowan is a representative—in general—the opinions of the social action department are also the opinions of the component parts, because there is room for a great exchange of opinion.

On the particular point at issue here there have been misunderstandings created by this little fight that we talked about. You remember when I appeared before this committee last year I was very careful to say I, too, believe in compulsory health insurance of some kind, provided you understand what I mean, what I want, and you remember what I said was this—I think the record will show—that every man by God's law is obliged to take care of his health, and by God's law also he is obliged to take care of the health of those dependent upon him, as that is part of the natural law. Now, the method by which a man takes care of his health, and the method by which he takes care of the health of those dependent upon him, is an entirely different matter. On that we can differ. As a matter of fact, Father McGowan, Monsignor O'Grady, and I will agree absolutely on the basic moral obligations regarding the care of health. In the same way, regarding the nature of government, I think government is intended to make it possible for every individual to realize the greatest possible potentialities, and to lend help and assistance wherever that individual either fails to do so, volunteers deliberately, for example, through crime, or where the individual does not have the opportunity, or where the individual chooses, through laziness, laissez faire attitude, not to do so. Now, the Government can come along and stimulate them and inspire, and even, if you want to say something like "coerce" in a mild way, but not enslave the individual to make him expend his highest possible potentialities.

So it seems to me, Senator, that with that kind of thinking we can see where Government should supplement the efforts of those who, of themselves, do not care to provide for their own health or for the health of those dependent upon them, or who can not do so. But it is not the place of Government to start coercing.

Now, when Father McGowan says that he believes in the insurance principle and quotes the encyclical of the Pope in favor of the insurance principle, and then quotes the bishops' manifesto after the last war, also in favor of the insurance principle, I am in favor of the insurance principle. I want people to buy insurance, but I do not want the Government to make me buy insurance That is all that I am talking about. Because, implied in the Government making me buy insurance there has to be a regimentation. I will grant you that it is abstractly possible to say that you could just simply have a law and stop there, providing that everyone must buy insurance, and then don't bother about the doctors and so on, but the way this was projected, the doctors came into the picture and there was regimentation of the doctors and regimentation of the nurses and regimentation of the people, and there was a whole army of regimented individuals. That is what I object to in this picture, Senator. We can argue about that from now till doomsday, on whether it is necessary, and I don't feel personally that you can get the best out of people by regimenting them.

Senator **Pepper**. Father Schwitalla, in no sense of the word would I suggest any argument or controversy, and I only want to call attention to the fact that there may be honest differences of opinion among honestly disposed people to the best method of achieving the objective.

Father **Schwitalla**. There is always the possibility of checking honest differences of opinion. If there are documents available which are objective and which state epochal events in life or history, on which my judgment or someone else's judgment is based, it seems to me those ought to be used to check the validity of the claim of one individual that he represents the honest opinion of himself.

Now, you brought up this means test, and let us dispose of that, because practically, so far as I am concerned, the means test has no fright for me. It is not a pauper's oath. A pauper's oath is one thing, and a means test is another thing. The hospital of the St. Louis University in St. Louis, Mo., is an institution in which 80 percent of the patients pay less than—not only less, but 50 percent pay nothing, 20 percent pay partial fee, and the rest of them pay not at cost but they pay $4 or $5 or $6 a day. How do we determine that? We have no fixed fee. The patron enters that hospital and he pays according to his paying capacity, and that paying capacity is determined by an individual that has had a lot of experience, and he sits down with some official of the hospital and a fee is suggested and that fee is referred to the hospital administrator, and the hospital administrator in conference with the patient who comes in says: "Can you take care of so much of this expense?" Now, that differs with the sickness. It differs with the circumstances of the individual. We include the whole of the expense, the doctors' fee and the hospital fee in determining whether the patient can pay that, and at the end of that conference we say: "You pay 25 cents a day," or "Pay 50 cents a day." There is no pauper's oath behind the thing. It is not a burden. It is an honest-to-goodness exchange of thought and opinions—"I would like to do this; I would like to do that." I like to talk it over with somebody who has a sympathetic attitude, just as I do with you. I think at times you must have done the same thing yourself. You have a financial adviser, you have an investment adviser, you have your health adviser, you have an adviser for your school children. It is that kind of thing, and that kind of thing can be administered on a local level, no matter how large the problem is, if you have enough finances to do it, and apparently that is the aim of this bill, to create that kind of personnel.

Senator **Pepper**. Have you noticed the spirit that the people in the Government have had under the social-security law in respect to compulsory requirement, and would you suggest that the feeling is one of regimentation?

Father **Schwitalla**. I would like to answer that question, but I am afraid that if I do start on it, it is going to be too long, but let me see if I can put it into two or three sentences.

Unemployment is one thing. Old age is another thing. Health is still a third thing. Now, when a person gets to the age of 65, when he participates or receives old-age assistance, you are still giving something to take care of the investment, but something that is in his organism, and that is where the difference lies between health care and unemployment and those other things. I don't think you can compare all those things. There are too many personal, inalienable rights of citizens that are bound up intimately with health, that are not bound up with employment, not even bound up with old age, where he would be getting old-age assistance.

Senator PEPPER. Thank you very much, Father.

Senator DONNELL. I would like to ask Father Schwitalla just a few questions.

I would like to say first that when you mentioned Father McGowan I for a moment confused him with Father McManus, who testified before the Labor and Public Welfare Committee on another occasion.

Father SCHWITALLA. Father R. A. McGowan, Senator.

Senator DONNELL. Father McGowan is located here in Washington?

Father SCHWITALLA. He is located here at 1325 Massachusetts Avenue.

Senator DONNELL. Yes; I know Reverend McGowan. I had the pleasure of being with him on occasion. What I want to call to your attention is two or three brief excerpts from this testimony of last year. Senator Pepper has quoted rather extensively from that testimony, and I would like to observe first the recognition by Reverend McGowan of the authority of Reverend Schwitalla with respect to the features, all features, in fact, or certain technical features, of S. 1606, which was the bill before the committee last year, and of which S. 1320 is the defendant, I should say. On page 1667, Reverend McGowan says:

> The social action department of the National Catholic Welfare Conference which is to present a statement on the bill to provide a national health program, S. 1606. We wish to speak particularly on the part dealing with national health insurance.
>
> Our department lacks the technical knowledge to appraise fully all features of the bill. Msgr. John O'Grady, director of the National Conference of Catholic Charities, and the Reverend Alphonse Mr. Schwitalla, S. J., president of the Catholic Hospital Association, will appear before this committee and can answer such questions.

I want to call attention also to a reference made by Father Schwitalla a few moments ago to the bishops' program. That was a program of social reconstruction that was entered into, or rather, projected, shortly after the First World War. Is that right?

Father SCHWITALLA. Yes, sir.

Senator DONNELL. And that bishops' program, a social reconstruction program, was before the Committee on Education and Labor on May 6, 1946.

Father SCHWITALLA. Yes, sir.

Senator DONNELL. Which was, I think, approximately the date that Father Schwitalla was here. I want to call attention to this portion of the testimony of Father McGowan appearing on page 1681, which refers to the contents of the bishops' program:

> Senator DONNELL. Mr. Chairman, I was not in this questioning primarily addressing myself to the probabilities of economic development in the country, but rather to undertake to determine what is exactly the theory of the bishops' program, and, as I understand it, to quote again this sentence:
>
> "Hence all forms of state insurance should be regarded as merely a lesser evil, and should be so organized and administered as to hasten the coming of the normal condition."

> I think that indicates the thought of the writer or writers not that state insurance is in itself a positive good, but that as it is stated here, it should be regarded as merely a lesser evil.
>
> Reverend McGowan. Yes.
>
> Senator Donnell. Under temporary conditions.

That appears on page 1681 of the proceedings to which I refer.

I would like to mention also the following commentary made by Father McGowan with respect to the operation of the voluntary system of health insurance in this country, appearing at page 1675:

> Senator Donnell. Father McGowan, in your statement at page 2 I observe that you say, among other things:
>
> "We recognize that the voluntary systems of health insurance which have rendered excellent service to our people would require some form of government aid to achieve universal health security."
>
> I take it from that, that your judgment is that voluntary assistance of health insurance have rendered excellent service already to the people?
>
> Reverend McGowan. Yes. Very good service.

Would you tell us, please, Father Schwitalla, what was the bishops' program generally, and by whom was it formulated?

Father Schwitalla. It was formulated by a group of bishops who were appointed by the bishops themselves. The Catholic bishops of the United States have formed a voluntary association. This is not an official body, for example, as the Vatican is. It is not that sort of thing at all. They do not touch upon matters pertaining to the essentials of the faith, and they do not touch upon the essentials of the organization of the church. They work in the periphery, the consequences of faith and morals. What I mean to say is you can easily see the Ten Commandments are translatable into a lot of practical programs, are they not, in order to implement, for example, honesty among people? You can do that in a lot of ways through education, through social influence, through recreation, and all kinds of other things. Those are consequences that come from the faith, you see. They are really stepping down from the basic truth of stepping up. You step sideways from the basic truth out into the periphery of daily life, and you may have less and less of the contents of faith and morals, and yet a lot of social guidance. It is that kind of thing that these bishops deal with. It is voluntary association, therefore, divided into a number of departments. There is a press department, there is a social action department, there is the department of lay organizations, and all that sort of thing. At the head of each one of those there is a bishop or a group of bishops, a committee of bishops.

The social action committee was one that organized, that wrote this—it was not an encyclical; it was a manifesto, I think they call them, as I recall it, I don't remember the details of that—and I think it was approved by the board of bishops afterward. The whole purpose of it was to try to lay down basic acceptations in the reorganization period following the war, to call attention to certain basic things that ought to be done for the American people, based upon the teachings of sound ethics and sound morals. That is all the church can do. and it covers a tremendous thing and will have a great deal of effect upon Catholics, and for that matter outside the Catholic Church, because, as you know, it is quoted today even by non-Catholic writers. Non-Catholic writers quote it rather extensively to this day as an expression of an authoritative group or semi-authoritative groups that carries a great deal of weight with it on account of the character of the people that wrote it.

Senator DONNELL. And bishops from all over the United States were members of this organization which formulated the bishops' program?

Father SCHWITALLA. Yes, all the bishops.

Senator DONNELL. And so far as you know, has there been any change by the organization to which you refer in its opinions with respect to this sentence which I again quote from the bishops' program:

> Hence, all forms of State insurance should be regarded as merely a lesser evil and should be so organized and administered as to hasten the coming of the normal condition?

Father SCHWITALLA. I do not believe any change in that. Now, don't forget, too, Senator that these bishops meet year after year and as you know, make pronouncements, many of which are sent to Congress.

Senator DONNELL. Thank you, Father. Are there any further questions?

Senator PEPPER. I have nothing further. I want to say for Senator Murray, Father, that he had to go to a labor conference. He is on the conference on this labor bill.

Father SCHWITALLA. I would like to have heard Senator Murray and see whether he has been converted.

Senator PEPPER. Father, I know the Senator will always be impressed with what you have to say, and I don't know whether he is going to convert you or you will convert him.

Father SCHWITALLA. We are both working on it, Senator.

Senator DONNELL. I hope you will come back again, if you have that view, that statement.

Senator PEPPER. Mr. Chairman, I would like to insert in the record a newspaper clipping, being a statement by a nurse, Miss Mary Lambie, director of the division of nursing of the New Zealand Department of Health.

(The newspaper clipping from the Washington (D. C.) Star of March 8, 1947, follows:)

[From the Star., Washington, D. C., May 8, 1947]

### "SOCIALIZED MEDICINE" WORKING IN OTHER LANDS, NURSES SAY

"Socialized medicine," bitterly disputed in America, is in successful operation in other lands, according to some of the foreign nurses now meeting here in the first postwar congress of the International Council of Nurses.

They conceded it has created many administrative problems, but they are convinced it is of enormous benefit to moderate and lower income groups in providing medical care they would otherwise be denied.

Among the delegates from 32 countries represented at the conference, none is better qualified to discuss the issue than Miss Mary I. Lambie, director of the division of nursing of the New Zealand Department of Health.

#### SAYS MIDDLE CLASS AIDED

Miss Lambie, who has been in close contact with the administration of social insurance in her country since passage of social-security legislation in 1938, said she thought families in the middle class were particularly aided by the measure.

The rich, she pointed out, can afford specialized medical treatment, while charitable aid or government relief is available to the very poor. But families of moderate means are hard hit when unexpected hospital costs must be met.

All sections of the populace, she maintained, should have access to proper medical care—not as a form of Government relief, but through a national insurance fund to which they have contributed.

New Zealand's social-security plan provides, among other benefits, free hospital care at public institutions or a third of the cost at a private hospital.

Physicians' attentions are obtained on a "fee-for-service" plan, Miss Lambie said. The government subsidizes each doctor's visit at a rate corresponding to $1.50. If the doctor charges above that amount the patient pays the difference.

A contract system proposed by the government, under which each patient would contract with a doctor for full medical attention at a rate fixed by the government, was tried out but failed to obtain the cooperation of the medical profession, she related. Under that system the entire cost would have been subsidized nationally.

### FINANCED BY INCOME TAX

The insurance program, of which the medical benefits are only one phase, is financed by a flat 10-percent tax on individual income. Although it is hoped to make the plan self-sustaining, Miss Lambie said, the government now supplements the fund from other tax sources.

Czechoslovakia has had health insurance since World War I, according to that country's delegates to the nursing convention. Not only is the individual cared for during illness, but his family receives financial aid to relieve distress while the wage-earner is unable to work.

The principal criticism of the present system the Czech nurses said, is that the benefits to workers' families are too small. The medical care itself, they asserted, is generally regarded as satisfactory. They said steps now are being taken despite the country's financial difficulties, to raise the workers' benefits.

Senator Donnell. Our last witness for this session is Dr. L. H. Schriver, Cincinnati, Ohio. Doctor, will you kindly state your full name and position and address?

## STATEMENT OF DR. L. HOWARD, SCHRIVER, CINCINNATI, OHIO, PRESIDENT OF ASSOCIATED MEDICAL CARE PLANS

Dr. Schriver. Mr. Chairman, my name is L. Howard Schriver, M. D., Cincinnati, Ohio. I am a graduate of the University of Cincinnati School of Medicine, 1910. I am engaged in the private practice of surgery in Cincinnati, attending surgeon to Christ Hospital, the Jewish Hospital, Children's Hospital, Concinnati. I am professor of surgery at the University of Cincinnati Medical School. I am past president of the Public Health Federation of Cincinnati Academy of Medicine, past president of the Ohio State Medical Association and president of Associated Medical Care Plans, Inc., president-elect of the Conference of Presidents of State Medical Associations in the United States.

Senator Donnell. I wish you would just tell us a little more about that last organization, if you will, Doctor.

Dr. Schriver. You mean the Conference of Presidents?

Senator Donnell. Yes; the one of which you are president-elect.

Dr. Schriver. Yes, sir.

Senator Donnell. That is, you will serve next year?

Dr. Schriver. Next year, from June 8 of this year.

The Presidents' Conference is an organization made up of presidents at the time of organization of State Medical Associations, and the membership is to include permanent membership; in other words, the past presidents of that State continue as members. The organization's intention was to study thoroughly medical problems, social problems, that involve medicine, and out of these studies make certain recommendations to the American Medical Association, which they have done at each convention of the house of delegates, brought in resolutions that they thought were constructive.

Senator DONNELL. Who is it that elects the president of this organization?

Dr. SCHRIVER. The membership in general, at the membership meeting.

Senator DONNELL. That is a meeting, I take it, of members from all parts of the country?

Dr. SCHRIVER. Yes, sir.

Senator DONNELL. Now will you proceed with your testimony, Doctor?

Dr. SCHRIVER. Senator Donnell, I am here in a dual capacity, and I would like, with your permission, to introduce into the record the statement of the Ohio State Medical Association whom I represent today. Unless time permits or you have interest in questioning me, I would like to merely introduce this in the record as the statement of the Ohio State Medical Association.

Senator DONNELL. It may be introduced and will appear following your testimony.

Dr. SCHRIVER. Primarily I am here to represent the Associated National Care Plans, and I am——

Senator DONNELL. Doctor, I wonder if I could interrupt you just for a moment. While you are here testifying I would like at this time to have the record include this one paragraph of the statement which you have just presented on behalf of the Ohio State Medical Association:

> The Ohio State Medical Association has authorized me to appear before this committee for the purpose of advising the committee that the Ohio State Medical Association has endorsed Senate bill 545 in principle, and believes that it is a sound and practical program for improving and expanding the public-health activities of the Federal Government, and for establishing a plan of Federal assistance to those States which may need Federal funds to provide adequate mental and medical service for their citizens.

Proceed, Doctor.

Dr. SCHRIVER. My understanding is that the Associated Medical Care Plan was invited to come here to testify before your committee more or less as informative of what the association was and what its plans are.

The opinion of the American Medical Association with respect to S. 545 has been presented to this committee previously by R. L. Sensenich, M. D., chairman of the Board of Trustees of the American Medical Association. In that statement Dr. Sensenich indicated that Senate bill 545 more nearly approximates a legislative background for the development of a health program for the American people without destroying or restricting the objectives set forth in the broad national-health program of the American Medical Association.

Further evidence of the interest which the American Medical Association has taken in the development of prepayment medical care plans on a voluntary basis is seen in the establishment of the Council on Medical Service in 1943, whose chairman, Edward J. McCormick, M. D., has also appeared before this committee. Dr. McCormick has presented information which indicates the rapid spread of voluntary prepayment medical care plans during recent years, a fact also referred to in the testimony of J. Douglas Colman, representing the Blue Cross Commission.

Facts such as those submitted by the Blue Cross Commission are self-evident proof of our contention that voluntary plans, medical as well as hospital, are capable of providing a solution to a portion of the problem of more adequate distribution of health care.

We find ourselves in perfect agreement with the opinions already voiced by the above-mentioned witnesses, representing the American Medical Association, the AMA Council on Medical Service, and the Blue Cross Commission.

Our purpose in appearing before this committee today is to relate the development of Associated Medical Care Plans, and the role we expect this organization will play in the further strengthening of nonprofit prepayment medical-care plans. This information is provided in view of reference made in S. 545, part B, to the authorization of funds to provide for the furnishing of medical care through the ultimate medium of voluntary medical funds, operated not for profit.

Background of Associated Medical Care Plans: Shortly after the issuance of its national health program in December 1945, in which the American Medical Association specifically endorsed the establishment of voluntary prepayment medical-care plans, the board of trustees and the Council on Medical Service agreed upon the necessity for creating a strong national organization of such plans.

Previously there had existed an informal Council of Medical Care Plans of America, functioning during the years 1943–45. Invitations were extended to the leaders of this group to meet with representatives of each medical-care plan, the Council on Medical Service, and officials of the American Medical Association to draft plans for a national association.

Associated Medical Care Plans was organized in February 1946 and incorporated 1 month later as a nonprofit corporation in Illinois. Although a separate corporation, AMCP carries the wholehearted endorsement of the American Medical Association, and functions cooperatively with the Council on Medical Service in seeking to achieve the objectives set forth in the national health program.

AMCP as an organization: Briefly, Associated Medical Care Plans is a voluntary association of nonprofit prepayment medical-care plans, a counterpart to the Blue Cross Commission, established for the purpose of coordinating nationally the effort of each of its individual member plans.

At the present time there are 39 plans affiliated with AMCP, the remainder of which have, or will be submitting applications during the next 90 days, to be acted upon by the Commission at its next meeting in September. By September 1947 AMCP expects to reach its full organizational strength so that it can fully represent the national interests of all nonprofit plans.

AMCP's affairs are governed by a 13-man commission, elected at an annual meeting of member plans, 10 of whom are selected from persons directly associated with member plans and 3 of whom are nominated by the AMA Council on Medical Service. Liaison with the American Medical Association is thus assured, with majority control remaining in the medical-care plans themselves.

Purpose of AMCP: In broad terms the purpose of AMCP is to stimulate and assist the development of voluntary, nonprofit, prepayment medical care plans throughout the United States and Canada.

For plans which are now organizing this means the furnishing of technical data, consultant services, and general assistance to committees responsible for mapping out a workable plan.

The source of this information, in turn, is gathered from the older, established plans, permitting the new organization a sense of confidence and assuring them that costly errors will be rduced to a minimum.

Reference has already been made to AMCP as a counterpart of the Blue Cross Commission, a fact which is illustrated by a similarity of purpose common to both organizations. This similarity is further evidenced by the recent establishment of joint committees to correlate the activities of AMCP with the Blue Cross Commission.

Functions of AMCP: Criticism has been levelled at voluntary medical care plans to the effect that they were inadequate, their enrollment was insignificant, benefits too limited, costs of operation excessive, and scope of operations too self-limiting.

Nobody who has been associated intimately with these plans would presume to make a wholesale denial of these charges, even though they are subject to many qualifying observations.

The admission of weaknesses on the one hand, coupled with justifiable confidence in the progress made thus far, are sufficient to explain the need for AMCP and the functions it is designed to perform.

Enrollment in terms of many millions of persons is a perfectly normal goal for voluntary medical care plans. AMCP can, and will, contribute toward this end in many ways. By means of Nation-wide studies, conferences, and interchange of enrollment techniques among plans, the experience of each plan will soon become the common experience of all plans. Whereas enrollment during the early years of plan development was pretty well limited to employee groups in urban areas, new methods for enrollment of the nongroup subscriber are being developed rapidly. As quickly as each new method is tried and proved by one plan, the detailed experience is made available to all plans, systematizing what was once a dissemination of information only via the grapevine.

Prepared enrollment aids, literature, advertising copy, posters, and the many tools which are used by enrollment staffs will be handled in the same manner not so much because of a desire for uniformity or standardization but to enable each plan to gain access to the best and most efficient material available for enrollment purposes.

Public relations personnel are employed by every plan, developing acceptance in the mind of the public for the purchase of prepaid medical care. Many of the most effective mediums and outlets for public relations activity are national in scope, beyond the reach of an individual plan. AMCP will undertake to bridge that gap, functioning in behalf of all plans in presenting the voluntary plan to the American people.

Actuarial studies are the backbone of any prepayment plan which hopes to operate successfully over an indefinite period of time. Reliable tables of such information have been slow in developing, largely because no agency has been in a position to carry on the continuous studies which are necessary to the development of such data. AMCP is equipped with the facilities, both physical and personnel, to do this job effectively. Through the assistance of member plans, who will soon begin submitting their actuarial experience regularly to AMCP, these statistics will be accumulated, analyzed, and circulated among the plans.

Administrative efficiency is constantly being sought after by directors and managers of plans throughout the country. Operating on the theory that "several heads are better than one," the facilities of AMCP will be directed toward a pooling of administrative experience in order that overhead expenses everywhere can be maintained at an efficient minimum.

Reciprocity, in its many applications, can be achieved only through such an association as AMCP, and through which proposals are drafted and accepted by member plans for the free interexchange of membership privileges with a minimum of red tape.

Transfer of memberships has been possible on a limited scale heretofore, which will now be expanded to the ultimate limits. Contract benefits will become available on a reciprocal basis throughout the Nation, thereby vastly increasing the value of membership to the subscriber whose habits of travel make such arrangements mandatory.

Physician relations, involving the voluntary cooperation of the individual physician with the operation of his plan, have been the subject of much comment. It is our feeling that much of this comment is unwarranted and based upon exceptions rather than average experience. AMCP is in a position to draw upon the combined facilities of the American Medical Association, the member plans, and medical societies sponsoring those plans, to perfect a program of physician relations which will assure the widest possible cooperation from physicians everywhere. Doctors, as individuals, will cooperate most effectively on a voluntary basis, we believe, when information is presented to them logically, fairly, and with a proper understanding of the private practice of medicine. Such cooperation cannot be pulled out of a hat, nor achieved by compulsory orders. Cooperation is earned by the merit of the program involved. AMCP purposes to assist its member plans in earning that kind of cooperation.

Significance of AMCP: The mere fact that Associated Medical Care Plans is represented here this morning, speaking in behalf of the organized, voluntary, nonprofit plans, has some significance in itself. This is the first time that these plans have been thus represented. We believe that this brief presentation signifies a "coming of age" for the entire movement.

S. 545 contemplates the appropriation of Federal funds for the subsidizing of medical care for the medically indigent, with provision for the spending of these funds through established plans such as are represented by AMCP. We believe that the existence of AMCP is pertinent to the questions before this committee.

We believe that AMCP is significant at this moment because it lends encouragement to our hope that voluntary, nonprofit plans would be capable of assuming the responsibilities involved in a proposal such as S. 545.

As the president of AMCP, and a doctor of medicine, the members of this committee may have my personal assurance that our member plans would welcome the opportunity to extend their services through the assistance of the Government of the United States.

Senator DONNELL. Senator Pepper, do you desire to ask any questions of the doctor?

Senator PEPPER. Dr. Schriver, what has generally been the findings of the American Medical Association with respect to the need for some form of medical care in the United States at the present time?

Dr. SCHRIVER. I would say, Senator, that the American Medical Association has approached this problem very conservatively. I think the American Medical Association has appreciated its import upon the health and general activities of the people of the United States, and after long, tedious investigation they have, as evidenced in 1943, come to the conclusion that insurance coverage for health is constructive on a voluntary basis, and upon that basis they set up the Council of Medical Services to make further detailed, exhaustive studies of this function.

Senator PEPPER. Did that represent a finding of the association that the present system that we now have, the voluntary insurance plan, is not an adequate system to afford medical care to the people of the country?

Dr. SCHRIVER. You mean the present system of medical practice without insurance?

Senator PEPPER. Without insurance, yes.

Dr. SCHRIVER. I think that fundamentally all doctors are perfectly satisfied with the application of the present practice of medicine, with certain qualifications. Medicine is a very dynamic science. Medicine has made revolutionary advances, just as industry has made revolutionary advances, in the last 75 years. Unfortunately, the economics have not kept pace with scientific knowledge. I think medicine has come to realize that situation, that economics in this country have not kept pace with scientific advancement. For that reason they feel that it is much better to distribute the cost of medical care by insurance premiums, which most people, particularly those employed, could afford to pay and get medical coverage.

Senator PEPPER. And undoubtedly one of the basic reasons that led to that conclusion was the fact that the insurance principle and the insurance system makes it possible for the individual to budget the cost of medical care.

Dr. SCHRIVER. Yes, because, naturally the cost of medical care is an unpredictable thing, very definitely.

Senator PEPPER. Doctor, has the American Medical Association made any findings as to who are or what class, economically, of our people are medically indigent?

Dr. SCHRIVER. I think the probabilities are, Senator, that the attitude and definition we assume in Ohio will be applicable and acceptable by the profession in other parts of the country, and I must limit myself to that because I have no knowledge of the national definition. The medically indigent are those who can buy other necessities of life and cannot pay for medical service. Of course, "generally indigent" is another class that cannot be reached in this way.

Senator PEPPER. Have you laid down any general yardstick to determine who comes in those classes?

Dr. SCHRIVER. I think it is utterly impossible to lay down yardsticks. I think the ability of one to take care of his need is as variable as persons are variable. I don't think that income, in and of itself, is a criterion in all instances, and therefore I am of the opinion that the only way you can arrive at an intelligent conclusion as to who is medically indigent is by definite, personal treatment of that individual case.

Senator PEPPER. Let us take the families of the country who have a gross income of less than $1,000. Would you classify them as medically indigent?

Dr. SCHRIVER. I would think that under the present inflation there could be no argument but what those families—I assume when you say "families" there are two or more dependents in that group, totally dependent—where the total income is $1,000 or less, I cannot see how they can get the necessities of life and still pay for medical service.

Senator PEPPER. What would you say about families having a gross income of less than $1,500?

Dr. SCHRIVER. That I think is dependent upon the kind of medical illness in that individual family. If it is a purely minor illness of short duration and does not affect the breadwinner of the family but affects those who are not breadwinners, I think a lot of their minor illnesses might be cared for, but not catastrophic illnesses or surgical operations.

Senator PEPPER. Would you say the same thing about families having a gross income of less than $2,000?

Dr. SCHRIVER. There, of course, is the gradation again. As to the $1,000 income, there is no question; $1,500, minor illness. In the $2,000 class I think probably some people could even take care of short hospitalization without any assistance. I do not mean by that that it might not dislocate them a little bit for a short period, but I think they could probably take care of a short hospital duration without any assistance.

Senator PEPPER. Did the Committee on Medical Economics make a report in 1939, I believe, that families with incomes of under $3,000 need help to meet the cost of a serious illness?

Dr. SCHRIVER. I think that could be accepted as a general statement, but not as to catastropic illness or long hospitalization.

Senator PEPPER. Dr. Schriver, don't you favor the insurance principle over the means test of determining eligibility?

Dr. SCHRIVER. I prefer a combination of both, Senator. I agree that the insurance principle is, on a voluntary basis, probably a great part of the answer in the distribution of medical care.

Senator PEPPER. On a voluntary basis?

Dr. SCHRIVER. Yes. And as far as the means test is concerned, I still believe that the means test is a very fair application to the individual.

Senator PEPPER. Is it also a difficult test to apply?

Dr. SCHRIVER. No; not at all difficult.

Senator PEPPER. It is not at all difficult to tell how much one family should pay toward its medical care and how much another family should pay?

Dr. SCHRIVER. Not at all difficult for the person trained to do that job. I would say it is not possible for me to do that job, but as I see it in the practice of medicine, from my observation in hospital practice, I see no difficulty whatever.

Senator PEPPER. Would your idea be to require anybody to go into debt to afford medical care to their families?

Dr. SCHRIVER. That might be perfectly right to do under certain circumstances.

Senator PEPPER. Would it be desirable by some kind of insurance system to relieve people of the necessity of having to go into debt for medical care?

Dr. SCHRIVER. Quite right.

Senator PEPPER. So you are thoroughly committed to, and believe in, and today are trying to carry out the voluntary insurance plan?

Dr. SCHRIVER. That is right.

Senator PEPPER. Have you any opinion as to whether it is a fact or not that when you have a voluntary plan in effect, as a general rule the people who need it least are the most likely to become problems?

Dr. SCHRIVER. May I make a rather generalized statement in answer to that? I know of no vital service rendered the people of any community that they prize more and want more than medical service, and yet I know of no greater ignorance with reference to the procurement of a service than the general public knows about the procurement of medical service.

Senator PEPPER. You say "ignorance"?

Dr. SCHRIVER. Ignorance on the part of the public.

Senator PEPPER. And has it been your finding that people in the community who should become members and keep their fees paid up promptly do not do it?

Dr. SCHRIVER. I don't think we have had, Senator, sufficient experience for anyone to make such a positive answer. In the short experience that we have had in promoting prepayment voluntary insurance, health insurance, I find in my community people clamoring for it.

Senator DONNELL. Clamoring for what?

Dr. SCHRIVER. To get insurance.

Senator DONNELL. You mean voluntary insurance?

Dr. SCHRIVER. Yes.

Senator PEPPER. Have you any community that you would like to take as a test case and tell us what percentage of the people of the community are members of these plans?

Dr. SCHRIVER. For the reason that in our experience time has been short, and because of certain compulsory practices in the setting up of insurance, it makes it necessary that in the beginning of an insurance plan, nonprofit, prepayment voluntary plan of insurance, they must, in order to survive in their early history, take groups. The reason for that is because in the taking of groups only you get an average risk. You cannot take individuals at first. Therefore, there are thousands of individuals in my own community who do not belong to groups by employment and otherwise, and presently, under the present high medical indemnity, I am getting inquiries all the time from individuals, "When can I get this insurance?" We have not reached the place of maturity and reserve strength where we can do that, because the actuarial hazards are tremendous, and there are not in my community a sufficient number of people who really want the coverage. We are hopeful that very soon there will be.

Senator PEPPER. Isn't that one of the dangers that you have to always be careful about in insurance—to get wide coverage in the system?

Dr. SCHRIVER. That is quite right.

Senator PEPPER. As one of the disadvantages of the voluntary-insurance plan—and wouldn't that be one of the advantages of the compulsory-insurance plan, that practically the whole country would be under the latter plan, whereas you get a selection, a limited number of people, under the former plan?

Dr. SCHRIVER. I don't think it is a disadvantage as to the plan. It is a question purely of democratic development of the voluntary plan.

Senator PEPPER. Have you noticed any appreciable turn-over in the membership under your plan?

Dr. SCHRIVER. No; the turn-over has been very slight, practically none today.

Senator PEPPER. Very few people are falling out?

Dr. SCHRIVER. Yes, sir. Of course—I want to qualify that—we are young. We are only active in this business of the State of Ohio somewhat over a year, about 14 or 15 months.

Senator PEPPER. How many members do you have now?

Dr. SCHRIVER. From a year ago until today we have grown to plus 160,000 people covered.

Senator PEPPER. What is the population of Ohio?

Dr. SCHRIVER. I suppose about 6,000,000.

Senator PEPPER. Doctor, under your voluntary plan the doctors accept the schedule of fees for service, do they not?

Dr. SCHRIVER. Yes, sir.

Senator PEPPER. They enroll or decline to enroll in the plan?

Dr. SCHRIVER. That is right.

Senator PEPPER. They are free to stay out?

Dr. SCHRIVER. That's right.

Senator PEPPER. You lay down certain standards, I suppose, for doctors that you will accept?

Dr. SCHRIVER. I think the only standards are those who are legally entitled to practice medicine in the State of Ohio.

Senator PEPPER. Then do you lay down any rules whatever governing the conditions under which medical service can be afforded the members of the plan?

Dr. SCHRIVER. I don't quite follow what you mean.

Senator PEPPER. What I mean is, do you lay down any standards or any conditions under which the members may enjoy the benefits of these plans? Do you lay down any rules governing the disposition of the benefits?

Dr. SCHRIVER. No; I don't think we do, if I understand your point.

Senator PEPPER. What do your plans cover?

Dr. SCHRIVER. Our plans at the present time cover surgical, hospital, obstetrical in or out of the hospital, tonsillectomy in or out of the hospital; at the present time things that are normally in surgery, tonsillectomy, obstetrics—catastrophic illness.

Senator PEPPER. Any kind of operation surgery is covered by the plan?

Dr. SCHRIVER. Yes, in hospital, and some out of the hospital—fractures, tonsillectomy out of hospital, and obstetrics out of hospital.

Senator PEPPER. Does it include any nursing care?

Dr. SCHRIVER. No, sir.

Senator PEPPER. Does it include the hospital cost if the patient is confined in the hospital?

Dr. SCHRIVER. No, we work conjointly and collaborately with the Blue Cross, and our clients that have Blue Cross insurance.

Senator PEPPER. Yours is essentially for the medical care that the patient may receive?

Dr. SCHRIVER. Yes, sir. We have nothing to do with hospital care. We operate conjointly with the Blue Cross.

Senator PEPPER. Does it include general medical care by a doctor in the patient's home?

Dr. SCHRIVER. Not yet. We hope to.

Senator PEPPER. I notice here in the voluntary prepayment care plans in a pamphlet, that the eligibility requirements of your plan as you have testified are limited to employee groups, including attendants who are enrolled in a Blue Cross hospital plan. You require that as a condition to participation in your plan?

Dr. SCHRIVER. Yes, generally that is true.

Senator PEPPER. And that the benefits that you confer are—I quote from page 58 of this pamphlet——

> General surgical services in a hospital are only accepted for tonsil and adenoid operation and material care, which will be covered in office or home as well as in hospital.
>
> Medical care: None.
>
> Other services: None.

So this is for just general surgical work?

Dr. SCHRIVER. Surgical and obstetrical at the present time.

Senator PEPPER. Not "other medical"?

Dr. SCHRIVER. Not other medical. As I say, that is what we plan to do, to extend coverage to that.

Senator PEPPER. Now, take a husband and wife and two children as a family, how much would membership in your plan cost the husband annually?

Dr. SCHRIVER. In our plan the cost is $1.90 per month, about $21 a year—something like that.

Senator PEPPER. Do you recall how much the Blue Cross Plan will cost him for a hospital room? And under the Blue Cross Plan do they get any surgery for the family?

Dr. SCHRIVER. I cannot give you that accurately for family coverage, but I think it is about $6 and some cents a quarter—about $25 a year for Blue Cross coverage for the family.

Senator PEPPER. Does the Blue Cross Plan provide nursing care in hospitals?

Dr. SCHRIVER. No, sir; no special nursing care. The regular hospital nurses, but no special nursing care.

Senator PEPPER. Does the Blue Cross Plan provide for the medicines that might be used?

Dr. SCHRIVER. Yes, sir; any and all, irrespective of the cost. That is the case in our community. I cannot speak for them generally. For instance, there was a time when such drugs as penicillin and streptomycin were exceedingly expensive, and they were exempted, because they just could not be worked into the premium, but now the Blue Cross in my community handles that, too.

Senator PEPPER. Under your system, the Blue Cross Plan, the hospitalization and surgery would be about $46 a year for a family, I think?

Dr. SCHRIVER. I think that is about right.

Senator PEPPER. If the husband were making $150 a month and was covered by the Murray bill plan, he would pay 3 percent of his income up to $300 a month. If he made $150 a month, he would pay $54 a year for the complete coverage that the Murray bill contemplates.

Thank you very much, Doctor.

Senator DONNELL. Just a few questions, Doctor. Senator Pepper referred to a document issued by the bureau of medical economics of the American Medical Association in 1939. I have here what I think the Senator was referring to, revised in 1940. Are you familiar with that document?

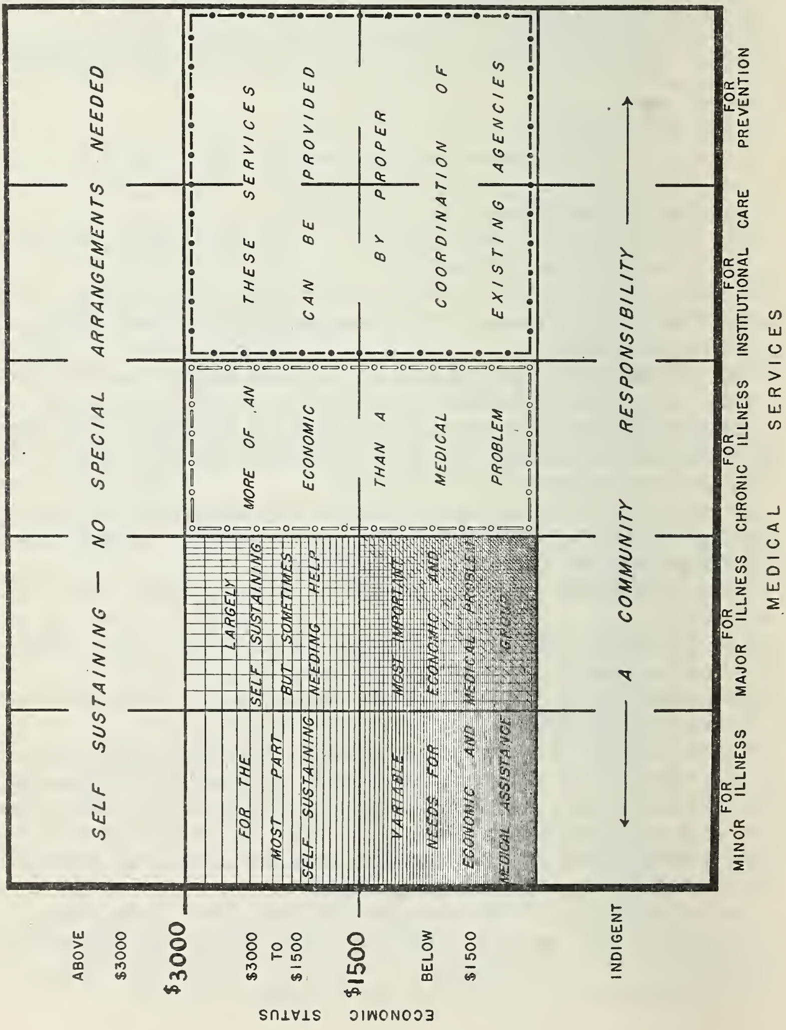
Dr. SCHRIVER. No; I am not familiar with that.

Senator DONNELL. Well, I will offer in the record Chart No. 39, entitled "Medical Services and Economic Status," together with the language appearing on page 91 of this booklet, which I will hand to the reporter.

(The material referred to follows:)

CHART XXXIX

MEDICAL SERVICES AND ECONOMIC STATUS


SELF SUSTAINING — NO SPECIAL ARRANGEMENTS NEEDED
FOR THE MOST PART SELF SUSTAINING
LARGELY SELF SUSTAINING BUT SOMETIMES NEEDING HELP
MORE OF AN ECONOMIC
THESE SERVICES CAN BE PROVIDED
VARIABLE NEEDS FOR ECONOMIC AND MEDICAL ASSISTANCE
MOST IMPORTANT ECONOMIC AND MEDICAL PROBLEM GROUP
THAN A MEDICAL PROBLEM
BY PROPER COORDINATION OF EXISTING AGENCIES
A COMMUNITY RESPONSIBILITY
FOR MINOR ILLNESS
FOR MAJOR ILLNESS
FOR CHRONIC ILLNESS
FOR INSTITUTIONAL CARE
FOR PREVENTION
MEDICAL SERVICES
ABOVE $3000
$3000
$3000 TO $1500
$1500
BELOW $1500
INDIGENT
ECONOMIC STATUS

### MEDICAL SERVICES AND ECONOMIC STATUS

The diagram on the opposite page is designed to show, in general, the relation between medical problems and economic status. The income limits used are illustrative only and should be raised or lowered somewhat according to the cost of living in the community under consideration, the number in the family, and other economic and social factors.

The diagram indicates the type of medical needs and the economic status which, combined, are responsible for individual or family medical problems. The diagram also suggests the organization of medical services that might be required by different economic conditions, and the limits within which any changes in present conditions might be considered desirable.

Senator DONNELL. Descriptive of this table, in order that our record at this point may indicate the general nature of the chart, I will state that it is a quadrilateral divided into five vertical columns and four horizontal columns. The vertical columns, describing them from left to right, are labeled respectively, "For Minor Illness," "For Major Illness," "For Chronic Illness," "For Institutional Care," "For Prevention."

To the left of the first column entitled "For Minor Illness," between the first and second horizontal lines, is the word "indigent"; between the first and second horizontal lines the words "below $1,500"; between the third and fourth horizontal lines the words "$3,000 to $1,500"; between the fourth and fifth horizontal lines the words "Above $3,000."

In the first horizontal column applicable as I read to "above $3,000," are the words "self-sustaining—no special arrangements needed."

In the second horizontal column and the first vertical column are the words: "For the most part self-sustaining"; in the second vertical column the words "largely self-sustaining but sometimes needing help"; in the third vertical column, "more of an economic"; in the fourth and fifth vertical columns the words, "These services can be provided."

In the first vertical column between the second and third horizontal lines are the words: "variable needs for economic and medical assistance"; in the second vertical column the words "most important economic and medical problem group"; in the third vertical column the words "Than a medical problem," coming under the words previously quoted "more of an economic" so that the entire inscription in the third vertical column between the second and fourth horizontal lines reads: "More of an economic than a medical problem." And finally, in the fourth and fifth vertical columns the words: "By proper coordination of existing agencies."

Finally, between the first and second horizontal lines, and obviously applicable to the entire five vertical columns are the words: "A community responsibility."

Doctor, I understand that you do not favor compulsory health insurance. Is that correct?

Dr. SCHRIVER. I do not.

Senator DONNELL. You do favor insurance on the voluntary basis?

Dr. SCHRIVER. Yes, sir.

Senator DONNELL. Have you had occasion, Doctor, to make a study of the tendency which compulsory health insurance has as regards the quality of medical or surgical service provided?

Dr. SCHRIVER. My observation has been, and my study led me to believe, that the quality of medical service, of necessity deteriorates under any compulsory health insurance plan. I would like to quote Haven Emerson, whom I look upon and I believe is probably one of the most objective thinkers in health in America, and he states that there is no evidence that compulsory health insurance in England or in European countries, where it has been in practice over a long period of years, has influenced beneficially either the public health or the individual health of the people.

Senator DONNELL. Would you tell us, Doctor, who Mr. Emerson is?

Dr. SCHRIVER. Haven Emerson was the head of the United States Public Health Association, has been a public health official in New York, and is, I think, accepted by those who are conversant with health activities and movements, as an authority on analysis and evaluation of health.

Senator DONNELL. He is a physician?

Dr. SCHRIVER. I think he is, Senator. I am not sure. He may be a doctor of public health. I am not sure.

Senator DONNELL. Approximately when was his observation made?

Dr. SCHRIVER. That observation was made within the last 6 months.

Senator DONNELL. Was it made in a book?

Dr. SCHRIVER. I saw it in print in a news item in which he dealt, at that time, at considerable length with the subject of compulsory health insurance as he has seen it evidenced in the countries that he quotes.

Senator DONNELL. Do you have a copy of that observation?

Dr. SCHRIVER. No, I do not.

Senator DONNELL. In this statement, Doctor, which you have submitted on behalf of the Ohio State Medical Association, at the bottom of page 2 is the language:

> Senate bill 545 contains many excellent provisions, including—

then I eliminate a portion on page 3 until we arrive at the fifth paragraph which reads:

> That which makes it possible for all local and State programs to operate on a voluntary rather than a compulsory basis.

You concur, I take it, in the assertion by the Ohio Medical Association that that is one of the excellent provisions of Senate bill 545?

Dr. SCHRIVER. Yes, sir. May I make one other observation, sir, that we are now talking about the Ohio State Medical statement, and I would suggest that lines 12 and 13 of the bill on the first page, I believe——

Senator DONNELL (interposing). Doctor, the first page does not have that many lines. It has only six lines after the title. You are probably referring to subdivision (b), page 2.

Dr. SCHRIVER. Yes, I mean on the second page the verbiage of the bill is as follows:

> That it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status, and medical, hospital and dental services to families and individuals having insufficient income to pay the whole cost.

The last words are my amendment to the section. In the bill it does not specify that medical and hospital services shall be limited to those having insufficient funds or insufficient income to pay the whole cost of such services.

Senator **Donnell.** I may interpolate at that point, Doctor, that the committee will be very glad to give consideration to your suggestion. I may say, and on behalf of myself, at any rate, that there is no intention, by the language to which you refer on page 2, to imply that it is the policy of the United States to provide medical, hospital, dental and public health services out of the public treasury to every individual regardless of race or economic status. This subdivision (c), so far as I am personally concerned, means, in substance, that the policy of the United States is to aid the States by filling in the difference between what nonpublic funds provide and what the entire needs are, rather than to indicate that this is to be a proposition under which everybody throughout the United States is entitled to come to the public treasury, State or Federal, and get his medical, hospital, dental and public health service free.

Dr. **Schriver.** Public Health Services, I think, should be applicable to all people. They should all be recipients of public health.

Senator **Donnell.** We are very glad to have your comments and criticisms, Doctor.

Dr. **Schriver.** Then on page 10, line 11, I suppose it was merely a typographical error, the words "Surgeon General" are used, and we are of the opinion that "Administrator" would probably be the word that would be more applicable here.

Senator **Donnell.** Now, Doctor, may I ask, do you have further suggestions?

Dr. **Schriver.** That is the only one I have.

Senator **Donnell.** I am compelled now to go to the floor and I don't want to cut you off, and I was going to suggest that if you have anything further you can file it for the record.

We thank you very much, Doctor, and the committee will now be in recess until tomorrow morning at 9:30.

(Whereupon, at 1:30 p. m., the subcommittee adjourned until 9:30 a. m., Thursday, May 29, 1947.)

(The brief submitted by Dr. Schriver follows:)

### STATEMENT REGARDING S. 545 TO BE PRESENTED BY L. HOWARD SCHRIVER, M. D., CINCINNATI 1, OFFICIALLY REPRESENTING THE OHIO STATE MEDICAL ASSOCIATION, AT HEARING BY SUBCOMMITTEE OF THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

The Ohio State Medical Association has authorized me to appear before this committee for the purpose of advising the committee that the Ohio State Medical Association has endorsed Senate bill 545 in principle and believes that it is a sound and practical program for improving and expanding the public health activities of the Federal Government and for establishing a plan of Federal assistance to those States which may need Federal funds to provide adequate health and medical services for their citizens.

With respect to the health activities and responsibilities of the Federal Government in the fields of health and medical care, the Ohio State Medical Association believes:

1. It should be the function of the Federal Government to provide only for those services in the field of health which local communities and States are unable to provide for themselves.
2. Certain States, including Ohio, have sufficient potential resources to provide adequate health services for their citizens. Such States should not expect to receive financial aid from the Federal Government unless critical economic conditions should develop within those States.

3. There are certain areas of the country which are unable through their own limited resources to provide their residents with adequate health services. Therefore, it is apparent that the Federal Government should be prepared to provide financial assistance, advice, and guidance to such areas.

4. Should it become necessary for the Federal Government to expand its health activities so as to provide financial aid to local areas and States which are in need of assistance, this should be carried on in accordance with certain sound basic principles.

The Ohio State Medical Association believes that the following basic principles and policies are essential in any Federal health program and that any program which may be adopted should—

(*a*) Insure services of a high quality;

(*b*) Place on State and local governmental agencies the responsibility for administration of the program and permit them wide latitude in administrative functions;

(*c*) Preclude centralized bureaucratic control and dictation on the part of any official of the Federal Government;

(*d*) Provide assistance only for those unable to provide themselves or their dependents with essential medical, hospital, and dental services;

(*e*) Provide for voluntary, rather than compulsory, participation by those eligible for such benefits;

(*f*) Encourage the continuance and development of voluntary service and insurance plans providing protection against the costs of medical, hospital, and dental services;

(*g*) Permit each beneficiary of a medical or dental service plan to select his own physician or dentist;

(*h*) Provide safeguards against extravagance, waste, and inefficiency;

(*i*) Protect the freedom and initiative of professional groups participating in the program;

(*j*) Allow professional groups directly concerned in providing health services a voice in the formulation of basic policies and regulations and an opportunity to serve in an advisory capacity on administrative details.

In the opinion of the Ohio State Medical Association, Senate bill 545 is in accord with the foregoing basic principles.

Senate bill 545 contains many excellent provisions, including—

That which creates a National Health Agency under competent medical administration and guidance, and within which the scattered health and medical functions of the Federal Government would be consolidated.

That which recognizes the principle of local responsibility and local control of all activities.

That which creates advisory councils, on which the medical profession would be adequately represented, to cooperate with those serving in an administrative capacity.

That which provides for a study of the activities of the proposed newly created agency and for a report to the Congress, in order that the Congress may be kept advised of the work and functions of the agency.

That which provides for studies and surveys of needs, existing services, and deficiencies in services—a scientific approach—before the appropriation and expenditure of funds.

That which makes it possible for all local and State programs to operate on a voluntary rather than a compulsory basis.

That which permits the distribution of benefits only to those who are unable to provide proper health and medical services for themselves, thus excluding those able to pay for proper health and medical services but including the so-called medically indigent in addition to those who are forced to look to Government for all necessities.

That which recognizes the need for improved dental services.

That which recognizes the need and value of better health and medical programs for school children.

That which recognizes the necessity for greater participation by the Federal Government in the field of medical and dental research.

That which provides for reviews and hearings by the advisory council on disputed matters, thus protecting the local communities and States from arbitrary and unreasonable action on the part of a central administrative authority.

That which would provide for participation by nonprofit organizations undertaking to provide on a voluntary basis insurance coverage for health, hospital, dental, and medical services and for the expenses of such services.

That which provides that the program shall be financed from current revenue; the funds must be specifically appropriated by the Congress; and the money spent only for the purposes for which appropriated.

In general, as previously stated, it is the belief of the Ohio State Medical Association that Senate bill is a sound, workable proposal. It avoids the evils and dangers which have been apparent or inherent in previous proposals for a national health program.

It is impossible to state at this time whether or not the State of Ohio will need to take advantage of the provisions of Senate bill 545 should it become a law or whether or not it will desire to participate in the proposed program.

It is true that at present the State of Ohio is receiving approximately $1,500,000 per year from the Federal Government for health and medical services administered by the Ohio Department of Health. Additional Federal funds are being spent by the Ohio Department of Public Welfare on a matching basis under the provisions of the Social Security Act.

We are not proud of the fact that the central office of the Ohio Department of Health has been forced to depend on a considerable amount of Federal money with which to carry on necessary and essential activities. Moreover, we are not proud of the fact that so many of the local communities in Ohio have become too dependent on Federal allotments for health work.

Efforts are being made at present to have the Ohio General Assembly correct that situation by increasing appropriations from State funds for health activities. Also numerous local communities in Ohio are taking constructive steps to make their health departments more efficient and to provide for larger appropriations from local funds for operating expenses.

We are convinced that this maladjustment can and will be corrected, for we believe that the State of Ohio is financially able to provide adequate health and medical services for all of its citizens.

The Ohio State Medical Association is not only taking the lead in efforts to have the State assume its full responsibilities in health matters but also it has adopted a forward-looking 25-point health program for Ohio, a copy of which is appended and should be considered as a part of this statement. All of the resources of the association are being utilized to promote this 25-point program, which, it will be noted, includes solid backing for Ohio Medical Indemnity, Inc., the medical expense insurance plan, organized and operated by the Ohio State Medical Association, in conjunction with the Blue Cross Hospitalization plans in Ohio.

However, regardless of the situation in Ohio, the Federal Government may find it necessary to establish a method whereby Federal assistance can be afforded to States and local areas which must look to outside sources for financial aid. In the future Ohio, too, may find it necessary to ask for assistance from the Federal Government as it did during the depression of the thirties.

Therefore, should the Congress decide that such action is necesary, the Ohio State Medical Association recommends that it follow the procedures, policies, and principles found in Senate bill 545.

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## The Twenty-five to Keep Alive

### OHIO STATE MEDICAL ASSOCIATION

### FOREWORD

The constructive, forward-looking recommendations for "A health program for Ohio," quoted on succeeding pages, were adopted by the house of delegates, the governing body of the Ohio State Medical Association on May 8, 1946, during the centennial anniversary meeting of the association.

It is the earnest desire of the association, its 88 county medical societies and 7,000 physician members to see such a program developed. They have pledged their active support and leadership to this undertaking.

The support and help of all the people of Ohio will be required to make this 25-point project a reality.

Your assistance is solicited.

### HIGH HOPES

All of us look forward to the years of reward—that happy period of life when we have leisure to enjoy to the fullest the fruits of our earlier years of labor and of steadfast devotion to duty.

Such enjoyment, of course, depends largely on the possession of good health. Good health, in turn, is affected by a number of factors—most of them easily controllable.

Now is the time to study these factors which vitally affect your health and that of all the people of Ohio. Now is the time to act to turn them to your advantage so you may continue to get the greatest happiness out of the present and to look with high hopes to the future.

### TWENTY-FIVE STEPS TO LONGER LIFE

The 25 proposals discussed on the following pages are considered fundamental to a sound health program for the people of Ohio.

They are advanced by the Ohio State Medical Association, which pledges to such a health program the active leadership and support of the medical profession of this State.

The conviction is firmly held that the opportunity for everyone to achieve and enjoy good health is a goal that can surely be attained, provided there is full cooperation among the people, the Government, unofficial agencies, and members of the medical profession.

Like charity, this program begins at home. It is an understanding that each of us, as individuals, can do something about—in our homes, our businesses, our local organizations, our communities. Don't wait until something "official" starts the ball rolling. Be a spark plug and get things moving yourself. The over-all health of Ohio can be no better than that of the locality in which you live.

1. *Economic improvement.*—"Efforts should be directed toward general improvement of economic and social conditions in all areas of Ohio. Elevation of living standards, elimination of the causes of unemployment, and removal of economic barriers will have an important bearing on the health of wage earners and their families."

Sponsor group study and discussion of the economic problems in your community. When enough people know the problems, individuals, and organizations can do much to remedy them. Make budget information available to families in the lower-income brackets. Encourage living within one's means.

2. *Improved housing.*—"Improvement in housing conditions is imperative. Programs in operation, or being developed, to eliminate slums and to provide housing conducive to healthful and hygiene living for all, deserve public support generally."

Encourage owners to keep rental property in decent condition and to open idle space for emergency occupancy. Civic groups should gather and distribute information concerning local housing needs. Local pressure will result in the desired action.

3. *Malnutrition.*—"A concerted attack should be made on the causes of malnutrition, one of the primary causes of ill health. Such a program should consist of efforts to teach people the value of a balanced diet and how to select nutritious food; to improve methods of food distribution; to restore the soil so it can produce nourishing foodstuffs; to raise economic levels so all may have the advantages of nutritious food. Presentation of activities to accomplish these objectives, sponsored by health agencies, medical groups, farm and conservation groups, and welfare and civic organizations should be supported and expanded."

Encourage farmers in better food programs through soil conservation and mineral enrichment—the basis of all nutrition. Support school efforts to teach better eating habits. Clubs can feature balanced-diet luncheons. Conserve food. Can food. Eat better and live longer.

4. *Sanitation.*—"Improvement and extension of sanitation safeguards are necessary. Adequate sewage-disposal systems, provision of adequate and safe public-water supplies, elimination of stream pollution, abolishment of vermin infestation, maintenance of adequate food and milk inspection, supervision of public eating places, health examinations for waiters, barbers, and others in direct bodily contact with the public, and similar activities, make large contributions to the individual and public health. State and local public-health officials charged with these responsibilities need the support of the public. They

should be provided with adequate funds for these functions. If additional legislation is necessary, it should be enacted."

Individuals and groups set the community standard. Set yours high. Make community cleanliness a matter of pride. Invite health officials to discuss problems with your organizations. Support your recommendations to eliminate health hazards.

5. *Smoke abatement.*—"Programs for the abatement of smoke, a nuisance, and cause of economic loss, should be adopted in all communities."

Housewives can make this their personal crusade because smoke multiplies housework, causes deterioration of drapes, curtains, shades, etc., increasing replacement expenses. Sponsor and support local campaigns to reduce this menace. If you own a business, see that firing methods are used that will eliminate smoke. Smoke-free air is healthful air.

6. *Communicable diseases.*—"Well-organized and properly financed programs to prevent and control communicable diseases should be carried on in all communities. This should include adequate programs of immunization and vaccination among preschool and school children. Official health agencies should be provided with adequate funds for this job, working in conjunction with the medical profession, school authorities, and others."

More progress has been made in communicable-disease control than most persons realize, but there is room for improvement. See that your local schools, factories, and business places adopt proper precautionary methods. Support programs for vaccination, immunization, and prevention. See that your community is up to, or better than, par. Your neighbors will be eager to cooperate when they know the facts.

7. *Venereal diseases.*—"Intensive warfare must be continued against venereal diseases. Health authorities and voluntary agencies in this field should receive widespread public support and the active cooperation of members of the medical profession."

Frank discussion and handling of this problem obtain highly successful results. Back your organization in making facts known, demanding controls. Encourage school and church educational programs. Acquaint your children with the dangers. Prudishness and snickering are the allies of venereal epidemics. Teaching the effectiveness of new cures will win confidence in them and result in cases being reported rather than attempts being made at quack cures or dangerous concealment. Sincere leadership can win this fight.

8. *Tuberculosis control.*—"Efforts to provide Ohio with adequate, modern facilities for the care of the tuberculous and with a program designed to prevent and control tuberculosis warrant the support of all Ohioans. The necessary legislation to accomplish these objectives should be enacted by the next general assembly."

Advance the war on tuberculosis with vigorous community action by clubs, organizations and individuals in backing the State-wide program launched by the joint committee on tuberculosis control. X-ray examinations in schools and places of employment produce good results in early detection of the diseases. Demand proper care of patients in your community.

9. *Health education.*—"Educational programs on personal hygiene and disease prevention should be expanded. The prevalence of controllable diseases, morbidity, and mortality from preventable causes can be sufficiently reduced if the public is properly and adequately informed, and will cooperate with physicians and health authorities by following their recommendations."

This program begins at home and can be most effective there. But community action centers in schools and in discussion groups. You will find few program subjects more interesting or more beneficial than authoritative presentations of health problems. Call upon your local, county, or State medical societies and health authorities for material and speakers.

10. *Physical examinations.*—"The value of periodic health examination performed by competent physicians should be emphasized and reemphasized in health-education programs. All physicians should prepare themselves to render this service to the public."

Some communities have the beginnings of preschool and school physical examinations—insist on adoption by your school board. Your clubs can help promote regular examination in factories and business places. And, most important, see your family doctor periodically for your own complete check-up.

11. *Cancer and chronic diseases.*—"Agencies sponsoring programs to control cancer and other organic diseases and to provide better faciilties for the care of those with chronic ailments should be supported enthusiastically by the public and the medical profession."

Educational programs are teaching the value of early diagnosis in saving many lives. Such programs can be sponsored by civic groups, the community chest, or by direct contributions. But to be effective, they must have the support of every individual. Your doctor will help. Health authorities will aid, too.

12. *Mental disease program.*—"Only a start has been made by Ohio in establishing a modern mental hygiene program and adequate facilities for the care and treatment of the mentally ill and mentally deficient. Additional funds to complete the job will be needed and should be supplied by the General Assembly."

Become better informed about the cure of mental diseases before they reach the institutional stage. Get facts about the relationship of physical and mental health. Find out what your schools do about abnormal pupils. If their methods can be improved, take the matter up with the school board. Demand adequate care for the victims of this tragic illness.

13. *Rehabilitation of the handicapped.*—"Present programs providing care and rehabilitation services for the handicapped and permanently disabled should be expanded, if and when necessary. Sufficient funds for the extension of these services, when needed, should be provided by the State and local governments."

Industrial, charitable, and governmental agencies are cooperating in many places to restore some degree of usefulness to the handicapped. This is an opportunity for industry to serve through training programs which help many persons to become self-supporting. See that your schools have vocational training programs for pupils handicapped in the normal types of study.

14. *Recreation facilities.*—"Greater attention should be directed toward improving recreational activities and opportunities for young and old. An adequate recreation program in each community will tend to reduce juvenile delinquency and crime, both of which breed physical and mental diseases. Groups sponsoring such programs deserve public support."

Most communities need more and better recreational facilities to keep children mentally, morally, and physically healthy. Community chests, YMCA, YWCA, church groups, and others are active in this way. Give them the support of your organization and neighborhood. Towns and cities will supply parks and playgrounds when voters demand that children have other places to play than crowded, hazardous streets.

15. *School health programs.*—"Many of Ohio's schools need better medical and health programs, including more adequate physical examination procedures and better instruction on matters of health. Greater cooperation between school officials, health authorities, and members of the medical profession on this important matter should be established in all school districts."

Parent-teacher groups, mothers' clubs and even luncheon clubs can be vital factors in seeing that every school has health education courses taught by trained personnel. Your school and medical leaders will tell your group the situation, problems, and goals. Sponsor activities to supply equipment and personnel for genuine, effective school work.

16. *Industrial health.*—"Constant efforts should be made to improve working conditions for all wage earners. Sound and properly supervised industrial health programs should be organized in all communities. The responsibiilty rests jointly on management, labor, the medical profession, and official health authorities. Elimination of health hazards in all places of employment, reduction of industrial accidents, and speedy rehabilitation of injured workers are goals toward which these groups should drive."

Enlightened employers know clean, airy, attractive working conditions are effective in reducing labor turn-over. Recommend safety measures where needed. Sponsor club tours through clean, well-planned plants. Make your community proud of its progressive employers. Put the pressure on, so plants in your community will adopt proper safety standards and institute good programs of health supervision.

17. *Medical care for the needy.*—"Those who cannot afford the costs of good medical care and hospital services should be furnished such care and services at public expense. This is a dual responsibility of the State and the local government. Adequate funds for such necessities should be provided. Cooperation between officials charged with this responsibility and members of the medical profession and hospital authorities is essential."

Ohio laws provide for care of the needy, including medical care. Primarily this is a local responsibility but State aid is available for communities which do their part. In too many instances, local areas fail to provide adequate money for this activity. See that your local officials make sufficient funds available. Coordination of relief activities will produce more efficient administration. Suggest that this be done in your county.

18. *State health department services.*—"Assuming that all citizens of Ohio are interested in the preservation and maintenance of their health, the people of Ohio generally should demand that Ohio's State Department of Health be provided with sufficient funds for the employment of competent personnel and for the maintenance of adequate facilities that proper service may be provided. The department is not receiving adequate appropriations from State funds. This is a serious problem—one which warrants careful study and prompt action by the next general assembly."

The Ohio Department of Health can be a source of valuable information and assistance on many health problems. It is doing a good job now but can do a much better job when provided with better support and more funds. Ohio is depending too much on Federal money, failing to meet its own responsibilities in this field. Ohio can stand on its own feet if the people make known their desires.

19. *Maternal and child health services.*—"Education and advisory services now being carried on by the State and by local health departments in the field of maternal and child health should be expanded to meet growing needs. State and local funds for this expansion should be provided. Work of various groups especially interested in such activities should be encouraged. Greater interest should be taken by the medical profession in such programs."

As a prospective mother it is the duty of every married woman to go to her family physician early in pregnancy to see that everything is progressing normally. And, to protect the baby in the important early stages of life, the family physician should be consulted to set up a definite schedule of examinations and immunizations.

20. *Hospital facilities.*—"Some areas in Ohio do not have adequate hospital facilities. This situation should be corrected as rapidly as possible through the extension of present hospital facilities or the erection of new institutions. A carefully conducted survey should be made to determine the areas in need of additional facilities. In the event the communities in which the need exists are unable to finance additions to present institutions, or new hospitals, State or Federal funds, or both, should be made available."

United community action is required to provide adequate hospital facilities in your area. Growing population and enlightened medical methods require greater facilities. See that your community has everything needed. However, careful study should be made before any steps are taken to be sure support is available and existing facilities are not being duplicated.

21. *Prepaid hospital care plans.*—"Extension of voluntary prepaid hospital service plans should be encouraged, as well as hospitalization insurance coverage offered by many reliable insurance companies. At present more than 2,000,000 Ohioans are enrolled in the Blue Cross hospital service plans and many more citizens are covered by insurance contracts providing hospital care. Individuals and families in the middle and lower income groups not now protected against the costs of hospitalization should be encouraged to secure such benefits which are available for moderate monthly payments."

Ask your employer to have a Blue Cross representative visit your company and explain their hospital plan. Find out what your own insurance man can offer. See that you are covered, and point out the advantages of such plans to those who do not have such coverage.

22. *Prepaid medical care plans.*—"Protection against the cost of medical care is available to Ohio wage earners and their families. Such protection may be secured by making moderate monthly payments to health, accident, and casualty insurance companies. Of special interest is the organization of a medical indemnity company by the medical profession of Ohio to meet a particular demand and need for a program whereby wage earners may budget the costs of medical care for themselves and their dependents on an insurance basis. Ohio Medical Indemnity, Inc., the "doctors' plan," is operating successfully in one area of the state and will expand its activities to other communities as rapidly as feasible. These voluntary methods which have been established to give Ohio's citizens an opportunity to protect themselves against some of the financial hazards of illness and disability should be supported and encouraged."

If you are not acquainted with the "doctors' plan" mentioned above, make it a point to find out what it offers. Ask your family doctor or county medical society.

23. *Care of disabled veterans.*—"Public support should be accorded programs being established to provide veterans with service-connected disabilities, with the best of medical care. Plans have been developed by the Ohio State Medical Association in cooperation with the Veterans' Administration and veterans' or-

ganizations to provide the disabled veteran with an opportunity to receive care at Government expense from physicians in his own community. Similar plans whereby the disabled veteran may receive hospital care in civilian hospitals in his own community are being worked out. These programs should be encouraged as they will make it possible for the veteran to receive his medical and hospital care from competent physicians and efficiently operated hospitals of his own choice and in his home town."

Every veteran should become familiar with the various plans being worked out for his benefit. Local chapters of veterans' organizations should discuss these plans at their meetings and take any action that seems necessary. These organizations should provide veterans with detailed information about the home town medical care plan of the Ohio State Medical Association. Veterans' organizations should cooperate with county medical societies to see that their members get proper care.

24. *Rural health.*—"The medical profession and farm organizations are endeavoring to find the solution for existing health problems in rural areas of Ohio. Public support should be given to these activities. Adequate services and facilities are not available now in many rural sections of the State. Such services and facilities should be supplied Some rural areas do not have an adequate number of physicians. Increased efforts should be made to attract physicians to such areas.

"A concerted attack should be made on some of the basic problems of rural health. Stronger and better financed local health departments better able to provide adequate services, are needed in many rural areas. Improvement in sanitation is imperative. Better programs for the control of communicable diseases are required. Good health education programs should be initiated. Many of these activities are questions of local responsibility and local administration but assistance from the State should be made available where local communities are unable to meet adequately all of the problems which arise."

Give your support to efforts which are being made by farm organizations and medical societies to solve the medical and health problems of rural areas. Voluntary action will produce beneficial results if there is sincere cooperation and sound planning.

25. *Medical education.*—"The youth of Ohio who desire to enter the profession of medicine as a career should be provided with opportunities to receive such an education. Expansion of Ohio's three medical schools will be necessary to meet increasing demands. Their efforts to expand and to improve their facilities should have the support of the public. Also, Ohio physicians should be provided with opportunities for regular postgraduate training so they may keep abreast of advances in the medical and closely allied sciences. Activities of our medical schools and hospitals in the field of postgraduate education should be encouraged. The postgraduate education facilities of the Ohio State Medical Association are being expanded for the benefit of the association's 7,000 members."

Encourage young people to enter the field of medicine. Service clubs and other civic groups can be of help by sponsoring scholarships for those who are interested and worthy. Support activities designed to provide postgraduate training for practicing physicians as the physician who is constantly increasing his knowledge by continuous study of newest developments, can render better service to his patients.

### WHAT YOU CAN DO TO BRING THIS ABOUT

*Healthful living*

First of all, familiarize yourself with each of these 25 proposals. They give you the basic problem, name the common enemies to better health and longer life. Then resolve to do your share to make this program a reality. That doesn't mean simply approving of the objectives. It means actually working to achieve them. You undoubtedly belong to at least one group. Enlist its aid in this program which touches the life of everyone so deeply. Work together with your local health authorities. Cooperate with your doctor and county medical societies. To establish and maintain this undertaking probably will involve both financial and other responsibilities. Assume them gladly.

Much of this can be accomplished through local and State responsibility, initiative and planning. In other words, the great State of Ohio and its prosperous communities can stand on their own feet.

# NATIONAL HEALTH PROGRAM

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## THURSDAY, MAY 29, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met, pursuant to adjournment, at 9:30 a. m. in the committee room in the Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Smith, Donnell, Murray, and Pepper.

Senator Smith. The committee will please come to order. I am going to ask Dr. Carl O. Flagstad to be the first witness. I understand Dr. Mead is engaged for a few minutes and he will be in shortly after 10 o'clock. So, Dr. Flagstad, we will be glad to hear from you.

Doctor, I see in the beginning of your statement that you give your background and biography, so to speak; it is probably adequate, but if you have anything further to add, it will be helpful for the record.

## STATEMENT OF CARL O. FLAGSTAD, D. D. S., CHAIRMAN OF THE COMMITTEE ON LEGISLATION OF THE AMERICAN DENTAL ASSOCIATION

Dr. Flagstad. My name is Dr. Carl O. Flagstad. I have been engaged in the practice of dentistry in the city of Minneapolis, Minn., for the past 35 years. I am also a professor in the School of Dentistry at the University of Minnesota, a position I have held for 35 years. I have been a member of the committee on legislation of the American Dental Association since 1935 and have been chairman of the committee for the past 3 years. The house of delegates of the American Dental Association has given the committee on legislation the authority to represent the association at congressional hearings.

The American Dental Association has a membership of 63,000 dentists, which constitutes 80 percent of the 78,000 dentists registered in the United States. The association has 58 constituent societies comprising all of the 48 States, the District of Columbia, each Territory and possession, and the Army, Navy, the United States Public Health Service, and the Veterans' Administration.

Within the constituent societies, there are 440 organized district dental societies located in all parts of our country. Each constituent society annually selects delegates as voting members at the sessions of the house of delegates which is the policy-making body of the American Dental Association.

For many years the American Dental Association has been supporting dental research for the benefit of the public out of the funds of the association. The American Dental Association has created and maintains fellowships at the Bureau of Standards and at the National Institute of Health. It also maintains a research commission at the Army Medical Museum and has supported dental research in many other ways.

These research projects are a part of the over-all objective of the American Dental Association to improve the dental health of the public. Our experiences during the past 20 years have demonstrated that the funds of the association together with the funds that have been furnished to us from private, endowment, and governmental sources have been grossly inadequate in comparison to our present needs for dental research.

Since the benefits that will develop from a more extensive research program will be of benefit to everyone, we believe that the Federal Government should support dental research with Federal funds.

The American Dental Association appreciates this opportunity of presenting its viewpoint concerning the National Health Act of 1947, S. 545.

The authors of this proposed legislation are to be commended on their efforts to produce an over-all health bill which is more nearly in accord with our professional concept than any previous comprehensive health bill hitherto introduced into Congress.

The committee on legislation has made an exhaustive study of this bill and, while it finds that many phases of the proposed legislation are in accordance with principles adopted by the American Dental Association, there is considerable concern as to whether the dental profession could carry out a program as extensive as provided by the bill. Since many of the States would need to develop the mechanism for carrying out a State-wide dental program, it is doubtful as to whether they could set up the organization and recruit the necessary manpower within the specified time. Therefore, the American Dental Association suggests a series of amendments which would give the States more latitude and permissive arrangement so that they could set up programs in accordance with their ability to carry them out and still be entitled to Federal funds as grants-in-aid.

The American Dental Association has recorded its stand on some of the basic philosophy of S. 545 as follows:

I. The American Dental Association is in accord with the principle of a Federal grants-in-aid system to aid States in meeting their health needs. On the basis of this principle, we had introduced into the Seventy-ninth Congress a "Dental grants-in-aid bill," S. 1099, for experimental programs in all phases of dental health. At the hearings last year on the Wagner-Murray-Dingell bill, S. 1606, we made this statement in support of the grants-in-aid principle:

> The American Dental Association believes that the grants-in-aid system has been effective in meeting certain health needs under the Social Security Act. The American Dental Association believes this system should be enlarged to meet all health needs and that there is no necessity for enacting a national compulsory prepayment plan.

II. The American Dental Association is in accord with the principle that dental health programs for children should be our major concern and that Federal funds as grants-in-aid to States should be available first for the dental care and treatment of children whose families are unable to pay the whole cost of such care.

The American Dental Association further approves the principle that the responsibility of a dental health program shall rest with the States and its communities. The State should determine the plan and have complete supervision of the dental health program within its State.

The American Dental Association has adopted four principles as being basic and fundamental in a dental health program for the American people. The third principle of this program is in reference to dental care.

Principle 3:

> *Dental care.*—Dental care should be made available to all regardless of income or geographic location. Programs developed for dental care should be based on the prevention and control of dental diseases. All available resources should first be used to provide adequate dental treatment for children and to eliminate pain and infection for adults. Dental health is the responsibility of the individual, the family, and the community, in that order. When this responsibility, however, is not assumed by the community, it should be assumed by the State and then by the Federal Government. The community in all cases shall determine the methods for providing service in its area.

A Dental Health Program for the United States, a bulletin issued by the American Dental Association, states—

> *Responsibility for dental care.*—The responsibility for providing dental care must be borne in the same manner as the responsibility for providing food, shelter, or any other essential of life. It is the American custom and tradition for the individual to attempt to supply these things for himself. If he cannot do so, the responsibility falls on the family, the community, the State, and the Nation successively. If each assumes an equitable share of responsibility, the problem of better dental health in this country is on the way to solution.

III. The American Dental Association is in accord with the principle as stated in the bill—

> to coordinate the health functions of the Federal Government in a single agency.

The house of delegates in 1938 went on record as favoring the establishment of a Department of Health in the Federal Government under the supervision of a Secretary—a physician—who would be a member of the President's Cabinet, with an Assistant Secretary—a dentist—to be Director of Dental Health. The National Health Agency is apparently created in lieu of a Department of Health. The American Dental Association believes coordination of the health activities of the Federal Government is desirable, but would favor a Department of Health rather than the National Health Agency, as S. 545 provides, for the following reasons:

A. The health of the Nation is of such paramount importance that it should occupy the place of greatest prominence in our Government. A Department of Health would have more prestige than a National Health Agency.

B. It is desirable for the Director of Health Activities to have direct access at all times to the President and to participate in the deliberations of the President's Cabinet. In times of national emergencies, such as war, calamities, and health crises, this contact would be especially valuable.

IV. The American Dental Association endorses title IX of S. 545—Dental research and new construction for dental research—for its provisions are substantially the same as those contained in research bills, S. 190 of the Seventy-ninth Congress and S. 176 of the present Congress, sponsored by the American Dental Association and introduced by members of this committee.

The American Dental Association's first principle as being basic and fundamental in a dental health program for the American people states:

> 1. *Research.*—Adequate provisions should be made for research which may lead to the prevention or control of dental diseases.

In the opinion of our association, this is the most important dental health legislation under consideration by Congress. The dental profession is grateful to the Committee on Labor and Public Welfare for the splendid support it has given our dental research bills. In the Seventy-ninth Congress the bill was unanimously passed by this committee and subsequently by the Senate, but became stalled in the House because of "must" legislation. It is our hope the full committee will soon consider S. 176 and pass it on to the Senate with the committee's unanimous endorsement.

If S. 176 should progress in Congress prior to S. 545, title IX could be eliminated, as it is practically a duplication of S. 176. The American Dental Association is grateful to the authors of the National Health Act for including the dental research provisions in their bill, as it indicates their approval and gives emphasis to the importance of the necessity for enacting such legislation. Adequate facilities for carrying on dental research are essential in our endeavors to control and prevent the ravages of dental disease.

### DENTAL HEALTH LIMITATIONS OF S. 545

There are certain limitations in the National Health Act on the use of Federal funds as grants-in-aid which, if liberalized, would make it possible for a State to set up more adequate and complete dental health programs.

I. S. 545 makes no provision for dental health education. The American Dental Association's second principle states:

> 2. *Dental health education.*—Dental health education should be included in all basic educational and treatment programs for children and adults.

There is no definite provision in S. 545 for the inclusion of dental health education in the State dental health programs. A complete dental health program should contain dental health educational activities in order to motivate people to take care of their teeth and of their children's teeth and to utilize present methods of prevention or controlling dental diseases. The American Dental Association has long advocated that dental health education, especially for children, should be a part of every dental health program.

It is our opinion that the value of a program of dental surveys and dental inspection, and even dental care, will be more effective if it is augmented by an intensive program in dental-health education. Many dental-health programs already exist in various States and communities, but most of them have been handicapped by a lack of adequate financial support. Since the National Health Act sets up provisions for a State-wide dental-health program, there will be the problem of reaching with dental-health education many rural districts which now have no facilities for such programs.

II. Since the establishment of a State-wide dental program in accordance with the provisions of S. 545 will be a pioneer venture in the States, it will be an extremely difficult task to develop these programs and place them into operation throughout a State. It would seem feasible during the period of development and planning that various programs could be in progress in designated areas of the State from which valuable information could be accumulated to be used in setting up a State-wide program.

Difficulties we see in the operation of the provisions of S. 545: Title VIII, part A, would appropriate $1,000,000 of Federal funds to be distributed to the States to assist each participating State to make a State-wide survey and inventory of existing dental care. The information thus obtained would be used in the development of a State-wide dental-health program. This is a desirable provision as it is sound administrative procedure to make a thorough study of existing conditions as a basis for the formulation of a future program. However, the survey will require considerable time and dental manpower to complete. There is some concern as to whether all States could undertake such a project in the immediate future, since the dental profession is extremely busy endeavoring to catch up on the backlog of dentistry accumulated from the war years when there was an extreme shortage of dentists.

Title VIII, part B. 812 (4) of the National Health Act of 1947 provides that Federal funds will be available to assist States in carrying on—

> a State-wide program designed and calculated within 5 years to provide for the periodic inspection of the teeth of all children in the elementary and secondary grades of public and nonpublic schools—

and the rendering of dental-care services to those children whose families are unable to pay for such costs.

This provision as stated at present is a difficult assignment for some States to fulfill, for to set up a State-wide program and to recruit the necessary dentists and to train sufficient personnel to assist in carrying out the dental services suggested would be almost impossible with their present dental manpower, especially within the 5-year period. It is this section of the bill which should be amended if the task is to come within the possibility of performance. We shall submit for the records factual data indicating the size and expense of carrying out this provision of title VIII, part B.

Title VIII, part B, also provides:

> 1. Such programs may also at the option of the State provide dental care for those families and individuals in the State having insufficient income to pay the whole cost of such services.
> 2. Such programs may include payments to dentists practicing in areas which without such payments would be unable to provide sufficient income to attract a practicing dentist.
> 3. Such programs may provide for the training of personnel for State and local public health work in dentistry.

These are commendable permissive arrangements for the States, but the problem at present is whether there are sufficient dentists and other personnel available to carry out these projects, although the money might be available.

Provisions for professional advice in the dental phases of S. 545: The American Dental Association's fourth principle states:

4. In all conferences that may lead to the formation of a plan for dental research, dental health education, and dental care there should be participation by authorized representatives of the American Dental Association.

The authors of S. 545 have recognized the importance of this principle.

It is our opinion the following provisions contained in the bill will be valuable in developing and indicating the direction of State-wide dental health programs:

1. The Director of Office of Dental Care Services in National Health Agency to be a doctor of dental surgery with at least 10 years of active practice and outstanding in the field of dentistry.

2. A National Dental Health Council consisting of Director, as chairman, and six members appointed by Administrator. The appointees shall be engaged in dental health work and at least four shall be doctors of dental surgery with not less than 10 years of active practice and licensed to practice in one or more States. The other two members must be familiar with the needs of dental care in urban and rural areas.

3. A State dental health advisory council to be appointed by the Governor, which shall include representatives of the State dental associations.

## SUMMARY

1. The American Dental Association is of the opinion a Federal grants-in-aid system to States for health programs is desirable and effective.

2. The American Dental Association does not have a complete answer to the problem of providing dental health for the people of every State and believes each State should have more freedom to develop its own program.

3. The American Dental Association believes that increased facilities for dental research are essential and that it is within the province of the Federal Government to provide these facilities. Therefore, it heartily concurs in title IX of the National Health Act. However, it would recommend to the Committee on Labor and Public Welfare the immediate passage of S. 176, the dental-research bill, as progress on S. 545 may be delayed.

4. The American Dental Association believes dental care should be extended to those unable to pay for such care but feels that any sound program set up for this purpose should be within the bounds of our ability to execute.

5. The American Dental Association believes dental health education of the public is an essential part of any State dental-health program. The periodic dental inspection of school children proposed in S. 545 is endorsed by the American Dental Association. Such an inspection program will not be effective unless it is accompanied by a dental-health education and a follow-up treatment program.

6. The American Dental Association believes, as S. 545 provides, that the States and communities should be responsible for the dental-health program within the State and that the program should be designed to meet its needs and ability to carry out.

7. The American Dental Association believes in a coordination of all the health functions of the Federal Government, but favors a Department of Health over a National Health Agency.

8. The American Dental Association endorses the nonprofit voluntary prepayment plan for the distribution of health services and is in accord with the provisions in S. 545 which would permit States to utilize this method for providing health service to those unable to pay for such care. While adequate prepayment plans are not at present in operation for dental services, they are in the process of development.

Amendments: The committee on legislation offers the attached amendments to S. 545 for your consideration. This change would eliminate certain definite requirements in title VIII, part B, which will have a tendency to discourage States from endeavoring to undertake the dental-health program.

The proposed amendments to S. 545 are as follows:

Title VIII, part B, section 812 (a), page 31:

On page 31, strike out lines 8 to 18, inclusive, and the first four words of line 19, and insert in lieu thereof:

> (4) Set forth a State-wide program designed to provide for the periodic inspection of the teeth of all children in the public and nonpublic schools in the State in such age groups as shall be determined by the State; and to provide for the dental care and treatment of dental diseases and dental defects of all children in the public and nonpublic schools in the State, in such age groups as shall be determined by the State, who, and whose family or guardian, have insufficient income to pay for the whole cost of such services. Such program may also, at the option of the State, contain any one or more of the following provisions:
>
> (A) Provide for the periodic inspection of the teeth of all children who are not in the public or nonpublic schools in the State, in such age groups as shall be determined by the State; or
>
> (B) Provide for the dental care and treatment of dental diseases and dental defects of all children who are not in the public or nonpublic schools in the State in such age groups as shall be determined by the State; or
>
> (C) Provide a State-wide program for the development and maintenance of effective means for education of the public concerning dental diseases and dental defects. Continue on page 31, line 19, of the National Health Act, S. 545.

Senator Smith. Doctor, there is a problem, as you present in your statement, that it seems to me it would be important to consider. Right in the beginning, on page 1, you say there are 78,000 dentists registered in the United States. We have a population in the United States of approximately 140,000,000 people. That suggests that we are terribly undermanned in this whole field, and I am wondering what the thinking of your association has been along the line of picking up that lack of dentists that we need for an over-all national program which, I think, we all agree is desirable. In other words, that can't be accomplished simply by spending money. You have to get the personnel and they have to be screened and they have to be educated, and we have to think in terms of a pretty broad program to train them, and we need, of course, years to develop this adequate program. Am I correct in that?

Dr. Flagstad. That fact has been brought out in our statement. We feel at the present time that our manpower is somewhat limited. However, efforts are being made to overcome it by increased attendance in our dental schools; there have been created some new dental schools, and perhaps by the greater use of auxiliary help such as health and dental hygienists they can be used in much of this inspection work. They are being used now in some communities where these programs are in effect. We also advocate limiting the program to the ability of the community to carry it out.

Senator Smith. Let me ask you this: You emphasize—and I think you do so correctly—that the first attention should be given to the children in school—that the children should get dental inspection. I agree with you on that. Can you deal with that problem with any less than the best-trained dentists? Can you rely upon just ordinary partly trained people to cover the ground in that respect—people working under the direction of a dentist in that area?

Dr. Flagstad. We cannot deal with what you term "partly trained" people, but we do have professional help in the dental profession who are dental hygienists and who are trained in this particular respect and are being used somewhat in the schools now in many programs. We have a man with us today who can discuss for you such a program which is in operation. We contemplate that they would have to have supervision and that in many of the places dentists would be used to a great extent. But it can be augmented by other professionally trained help, not people that you can pick up. We can also perhaps train some of our county nurses who are now being used in the county for health services.

Senator Smith. They would probably be the type of person who could say that this difficulty exists, but they wouldn't be qualified to treat the child.

Dr. Flagstad. They would be used in the inspection program chiefly, not in the dental-care program. The dental-care program is entirely in the hands of the dentist. Nobody is qualified or legalized to do that except the dentist.

Senator Smith. Of course, in the field of dental care, 78,000 dentists for our entire population is grossly inadequate. I am thinking now in terms of how to build that up in an over-all national program.

Dr. Flagstad. We recognize that.

Senator Smith. I notice that you favor a department of health. There has been a bill entered to establish, I believe it is called, the Department of Public Welfare, which would include health, social security, and all welfare matters. Are you one of those who feel that a separate department of health is desirable and not to combine it with these others?

Dr. Flagstad. We offered testimony when hearings were held on those bills. We are on record as favoring a department of health without combining with the other two agencies which were included in those particular bills.

Senator Smith. And you recommend an assistant secretary of health to have charge of the national dental program——

Dr. Flagstad. To be director of dental care or dental health, whichever you wish to call it.

Senator Smith. In the field of research, which interests me a great deal. I have always been interested in that field. We have just passed in the Senate the Scientific Research Foundation which has a division of medical research, and it is contemplated in the development of that division, if the science bill goes through, that we would have a branch, I assume, under medical or dental research. I am wondering whether it isn't better to put them all under headings: Cancer, heart disease, etc., etc. Wouldn't it be best to develop our research under that heading rather than to have a separate bill for dental research.

Dr. Flagstad. I am not familiar with the bill and the plan. I would say this, however, that dentistry has felt for a number of years that in receiving its allotments from medical funds we have always suffered and have not received our fair share. We want funds earmarked definitely for dentistry. Senator Murray, a member of your committee, has been very helpful and very active in the last few years in helping us introduce such types of bills, and S. 176 and also title IX of this bill are on that basis, to get the funds earmarked for dentistry. Our funds so far have simply been funds which have been given to us through the generosity of medicine. We want an institution of our own out there at Bethesda where we can carry on dental research, and that is the purpose of the present bill in Congress and the purpose of the bill that was in the Seventy-ninth Congress. The bill, S. 176, now carries the names of quite a number of the men on this committee.

Senator SMITH. Now you refer in your statement to dental health education. That doesn't mean inspection of children, but it means educating people from childhood up as to the importance of the care of the teeth. Is that your idea?

Dr. FLAGSTAD. That is the idea: Programs of lectures on mental health to the children. There are some such programs in operation now giving information concerning dental health, and also some training in the care of their teeth and also programs to parents and teachers associations and dental health publicity in the proper places. The dissemination of proper kind of information regarding the problem of dental health. It is a motivating force to stimulate people to care for their teeth.

Dental inspection without some of this dental health education would be useless. Some of these programs which are in effect perform the dental inspection and inform the parent regarding the child's condition. Then they have a follow-up program where the child goes to the dentist and returns showing the teeth had been taken care of. Such programs are what constitute dental health education, Senator.

Senator SMITH. Would it be your thought that that would be taught in public schools?

Dr. FLAGSTAD. Part of it would be taught in public schools and part of it would be taught in organizations, wherever we can get favorable publicity in the right place.

Senator SMITH. Wouldn't such hygiene and health be part of the education of the child's upbringing, part of the whole program?

Dr. FLAGSTAD. It would not, unless you set it up as a separate arrangement in the schools. It will not receive the attention that it should receive.

Senator SMITH. Wouldn't that be more a problem for the public schools in the various States to develop under the advice of an organization like yours? It wouldn't be a matter for Federal legislation. It would just be part of an over-all policy, I take it.

Dr. FLAGSTAD. To interest schools in putting on programs of that kind?

Senator SMITH. I am just wondering how to deal with it.

Dr. FLAGSTAD. We feel that if money is available for this particular purpose and it is matched by funds from the State and the community, that it will encourage the development of dental health education programs within the schools and outside the schools. Our point is to get the message over to the people.

Senator SMITH. Would you suggest that programs of that kind be under the Public Health Service, where I understand they are at the present time, or under the proposed dental set-up in S. 545? Can the Public Health Service handle that, do you think, or should we have a special provision?

Dr. FLAGSTAD. The Public Health Service has to some extent at the present time. My thought would be that this would augment the Public Health Service program and that we would have trained people who could present it and who would be definitely assigned for that particular purpose. In our schools in Minneapolis we have such a program. We have trained a group of dental hygienists who give lectures to the school children to carry on a follow-up program. They are not under the Public Health Service, but under the board of education with a dentist as director, and I think they are efficient, particularly in meet the needs of the schools.

Senator SMITH. Well, Doctor, I would like to ask you one further question on this whole situation and that is this: Isn't it a fact that we are experimenting, you might say, in this new field; that we are trying to find ways and means of meeting this over-all national health situation, including the dental care of the children? Is it wiser to try to blueprint a plan for the whole country or is it wiser to encourage the States to institute their own programs? I notice you emphasize that, if left to the States, it might lead to a variation in the development of plans. Would that variation be desirable as giving us experience in trying different approaches which will aim ultimately, of course, in getting an over-all program that would meet all our needs?

Dr. FLAGSTAD. I think it is impossible to develop a national program that will fit into every place in the United States. We are on record in the hearings last year and are on record now that we are for community design of the program, absolute community design, and supervision of the program. There is a difference in different counties. The condition in our State is entirely different than it is in Mississippi. A program set up for us would not be a desirable program for them in that section of the country. The country varies, so that I can't see how a Federal program can be set up. We are pleading for community and State control of the program.

Senator SMITH. And you think it is better to have a plan for grants-in-aid to the States to develop their own programs than an over-all program?

Dr. FLAGSTAD. Yes, that is right.

Senator SMITH. Now I notice you don't approve of the principle of compulsory health insurance. Is that because you don't think we are prepared yet to deliver the goods, so to speak, for the pay-roll deductions that might be made?

Dr. FLAGSTAD. Our testimony on that subject is in the hearings on S. 1606, and I think that covers it very well. The American Dental Association hasn't as yet changed its views. We haven't had a chance to study the new bill that is just out and I am not prepared to pass judgment on the new bill.

Senator SMITH. Senator Murray just filed a new bill.

Dr. FLAGSTAD. I have seen the bill.

Senator SMITH. You have seen the bill?

Dr. FLAGSTAD. Yes; I have seen the bill.

Senator SMITH. Now, I gather that you feel from the terms of our bill, which call for readjusting these things in a 5-year period, that you feel in the dental field at least that that is too short a period to mobilize your resources, so you would like to have a further extension of time in developing this program.

Dr. FLAGSTAD. Yes; and we would like to remove the limitations in the specific requirement.

Senator SMITH. I think the object in putting in the time limitation is to try to speed the program up so that we would move as rapidly as possible in developing the State programs. I don't think it is the purpose to say if you have got a perfectly good reason for not having done it, we aren't going to give you a greater chance, but I think probably in your field you would need more time than they might need in the straight health field.

Dr. FLAGSTAD. There are some States that could do it, but they are very few. It will be a new venture in many States to have a State-wide program. We have many programs somewhat of this type, and in those places they carry on very well. However, they are local. But there are very few places where we have a State-wide program. We do have one State which has a State-wide program, but not as extensive as suggested in this bill. We have asked for the privilege of setting the age and we have also asked for the privilege of setting up the program in accordance with the community's ability to carry out the program.

I can appreciate the idea of the committee to speed this thing up and to encourage States to undertake this program and get it under way as rapidly as possible. That is a good idea, as sometimes I think we need that type of prodding. However, we feel that if the States were given a little more latitude by removing the time period entirely, it would encourage them to undertake it.

Senator SMITH. Senator Murray, have you some questions you would like to ask?

Senator MURRAY. Yes. Doctor, we are all very well acquainted with you. You have testified on several occasions, both in connection with the national compulsory health bill and also in connection with the dental research bill. The dental research measure is a measure which has been proposed by the American Dental Association. I understand it was the result of very extensive studies of your organization——

Dr. FLAGSTAD. That is right.

Senator MURRAY. And the bill as filed was entirely in conformity to the requirements of the American Dental Association——

Dr. FLAGSTAD. That is right.

Senator MURRAY. And had the approval of your organization.

Dr. FLAGSTAD. That is right, Senator.

Senator MURRAY. The bill passed here in the Senate before. It was reported favorably by the committee after closed hearings and passed in the Senate, but was lost in the House.

Dr. FLAGSTAD. I don't think it was lost in the House, Senator. It died in the House.

Senator MURRAY. It got lost in the shuffle at the tail end of the shuffle there.

Dr. FLAGSTAD. There is a little difference between lost and died.

Senator MURRAY. That is right. But I think it is very much alive, because since that time, the bill has the honor of being sponsored now by several very distinguished Members of the majority party in this Congress. Senator Taft is on the bill and Senator Morse and Senator Aiken, and I believe it is universally accepted by both parties in the Congress and by the American people who have investigated it. They realize that it is a most important measure for the welfare of the people of this country and we are all very anxious to see it, and I am very glad to note that you recommend it be passed now and not be held back on account of the danger that other legislation might not pass.

Dr. FLAGSTAD. Senator Murray, the American Dental Association favors the immediate passage of S. 176. We feel that it is the greatest advance that we can make in dental health as we will get dental health research rolling along in the proper environment.

The point I wished to make about it not being lost, Senator, is this, that I believe the House was favorable. The fact was the bill passed the Senate in the last few days of the Seventy-ninth session and there was considerable legislation of necessity you had to complete, and consequently, the House didn't have time to consider it. I want to thank Senator Murray. He has been very active in helping us with this dental research bill. The history of our efforts goes back quite a number of years and always he has been interested.

Senator MURRAY. I must say that my work was really based on the the aid that the American Dental Society gave us in connection with that proposal, and I am satisfied, as I said a moment ago, that the Congress generally is in favor of that bill. Now in connection with the national compulsory health insurance bill, you say you have seen a copy of the new bill which has been filed?

Dr. FLAGSTAD. That is about all, Senator. I have seen a copy.

Senator MURRAY. You know it undertakes to decentralize the administration.

Dr. FLAGSTAD. I read your press release.

Senator MURRAY. And I think it complies with your suggestions made here today with reference to allowing the States to set up the programs and to have more latitude in managing programs of that kind.

Now it seems to me, as you have said a moment ago, that it is difficult to have a comprehensive program that would apply satisfactorily in each State in the Union, and if each State is permitted to operate on its own basis, some States may develop excellent ideas that will subsequently be accepted by other States, and I think it is a very advisable method of handling the proposition by decentralizing the administration of the program. The present bill undertakes to do that, and I hope you will be able to give it your most careful study.

Dr. FLAGSTAD. May I say this, Senator, that I am not authorized to speak on the present bill. The American Dental Association is on record as being opposed to compulsory health insurance. Whether this bill will change their attitude, I do not know. We have a meeting in August and the bill will be discussed.

Senator MURRAY. Well, the new bill was based upon the criticisms that were made against it before, and we undertook to obviate those objections and to provide a bill that would meet with the requirements announced during the time the hearings were on.

Senator DONNELL. May I ask the Senator a question, please?

Senator SMITH. Senator Donnell.

Senator DONNELL. Does S. 1320, the new bill, abandon the principle of compulsory health insurance?

Senator MURRAY. No.

Senator DONNELL. It still maintains that principle?

Senator MURRAY. It still maintains it. The principal objection to it heretofore was the centralization of the administration, and that was one of the things that the Dental Society, as I understand it, felt was a very serious obstacle in the bill.

Dr. FLAGSTAD. That is right, but they are also on record as being opposed to compulsory health insurance. I don't know whether they will change their minds in connection with studying this bill. At the present time, we are committed to opposing that type of legislation.

Senator MURRAY. Anyway, that bill is not before us at the present time, but I was merely calling your attention to the new bill.

Dr. FLAGSTAD. Yes; I think every bill that has been presented is an improvement over the bill that has gone before.

Senator MURRAY. That is right. It was a very difficult program to present and it had the same experience in other parts of the world. I assume if it ever becomes a law, it will naturally be improved and it will be perfected as it goes along.

Dr. FLAGSTAD. I think the point you make about States trying out programs and getting information that is helpful to other States is fine. If we started out on a program as suggested in S. 545, we would have to take some of the experience of the States or local communities which are now carrying on programs similar to the one proposed in S. 545.

Senator MURRAY. With reference to the bill which is now before us—S. 545—your figures show that the entire $20,000,000 appropriated for this bill as a maximum for dental services in any year matched with State funds would not be able to provide sufficient funds for adequate care of children. Is that true?

Dr. FLAGSTAD. I think that, in general, is true. It is the reason we are asking for some permissive arrangements to change the program so that we can serve to the extent to which we can deliver the service and set up programs within our ability to perform. Just where we would change the program I don't know. It would depend considerably on the locality.

Senator MURRAY. But you do believe that under the bill providing for only $20,000,000 to be matched by the State that it would only allow approximately $1.50 per child on the average, that that would be sufficient to take care of the situation?

Dr. FLAGSTAD. We think that that would be a mighty good beginning if we can have some permissive arrangement as to the amount of dental care we are going to include in our program. It now requires elementary and secondary schools. It might be necessary to cut down on the secondary-school proposition.

Senator MURRAY. I notice in the table here that in Montana it would only allow 90 cents per child for dental care.

Dr. FLAGSTAD. The bill doesn't at the present time provide for all children even as it was written, Senator, because it provides definitely only for school children. It doesn't provide for all children—preschool children and those who are not in the schools.

Senator MURRAY. Your organization has gone on record heretofore against the idea of a means test in furnishing dental care and medical care. Isn't that true, Doctor?

Dr. FLAGSTAD. Our organization has not made a public statement to that effect, Senator. We are not in favor of applying the method federally. We are in favor of limiting at the present time the dental care to those who are unable to pay. The method of determining who shall receive this care should be entirely within the province of the community and the State and must not be tampered with by the Government. May I read again from my statement?—

> The responsibility for providing dental care must be borne in the same manner as the responsibility for providing food, shelter, or any other essential of life. It is the American custom and tradition for the individual to attempt to supply these things for himself. If he cannot do so, the responsibility falls on the family, the community, the State, and the Nation successively. If each assumes an equitable share of responsibility, the problem of better dental health in this country is on the way to solution.

We believe in the democratic way that if the people can take care of themselves, they should do so. We are in favor of taking care of those who are unable to pay.

Senator MURRAY. Are you in accordance with the resolution passed by the house of delegates of the American Dental Association wherein it opposed the establishment of a means test at the Federal level in a program of dental care, holding that the desirability of such test should be determined at the State level?

Dr. FLAGSTAD. We are in favor of local determination of who shall be entitled to dental care, whether it be the community or the State.

Senator DONNELL. Senator Murray, would you mind just holding that quotation from that resolution so that we might have it when Dr. Mead is on the stand?

Senator MURRAY. Yes; now do you think that any person who would have the administration of the dental program should be a dentist?

Dr. FLAGSTAD. That is right.

Senator MURRAY. And you believe that the dental research program should be under the direction and control of the dental profession?

Dr. FLAGSTAD. Yes; under the Public Health Service. It is placed in the Public Health Service, as you know in S. 176, and if I understand this bill, S. 545, the control is still in the Public Health Service. We have a dental director in the Public Health Service whose department would administer the research program.

Senator SMITH. Senator Donnell.

Senator DONNELL. Doctor, the American Dental Association for which you appear has been flourishing in the last year and it has made a very material increase in its membership; has it not?

Dr. FLAGSTAD. That is right.

Senator DONNELL. You have had 56,000 last year and you have 63,000 now, and of the two-thirds of the dentists registered, that is, registered dentists represented by your organization last year, you now have 80 percent. That is correct; is it not?

Dr. FLAGSTAD. That is the registered dentists. Seventy-eight thousand doesn't represent all the practicing dentists. There are many dentists registered who are not practicing because of age and other things.

Senator DONNELL. The point I am making is the American Dental Association is thriving and, in your judgment, fairly represents the opinion of the dental profession of the country. That is right; is it not?

Dr. FLAGSTAD. That is right.

Senator DONNELL. You referred last year in your testimony, which you made mention of this morning, as follows: With respect to the pattern of organization, you said this democratic pattern of organization with extensive membership in every State in the Union unquestionably give the American Dental Association the right to voice the opinion of the great majority of dentists in the United States. Do you still adhere to that judgment?

Dr. FLAGSTAD. That is right; I still do.

Senator DONNELL. Now, Doctor, just a moment or two on one or two preliminary matters. Your experience has been over a period of some 36 years in private practice; has it not?

Dr. FLAGSTAD. That is right.

Senator DONNELL. And you refer to being on the faculty of the University of Minnesota. You didn't state perhaps quite full the fact that not only are you a professor but you are chairman of the prosthetic dentistry at the University of Minnesota.

Dr. FLAGSTAD. That is right.

Senator MURRAY. You never practiced in Missouri, did you, Doctor? [Laughter.]

Dr. FLAGSTAD. I never practiced in Missouri; in fact I think I am a little closer to the dentists in Montana than we are to those in Missouri, for we educate many of the dentists you have in Montana as your State has no dentist school.

Senator DONNELL. The fact the doctor is not a member of our Missouri citizenry is a loss to Missouri and to him, but we appreciate his views, however, with regard to Missouri, which I know he shares.

Now, Doctor, I want to ask you this: On page 3 of your statement which you have presented to us this morning, you quote from the hearings last year on S. 1606. You quote this language:

> The American Dental Association believes this—

and I interpolate by the word "this" you are referring to the grants-in-aid system; and resuming the quotation—

> system should be enlarged to meet all health needs and that there is no necessity for enacting a national compulsory prepayment plan.

Do you still adhere to that view, Doctor?

Dr. FLAGSTAD. The American Dental Association hasn't changed its point of view. This is definite instruction from the house of delegates.

Senator DONNELL. Does your personal judgment in any sense differ from the quotation which I have called to your attention?

Dr. FLAGSTAD. No; it does not.

Senator DONNELL. Do you believe and adhere to that just as much today as you did on April 21, 1946, when you were here?

Dr. FLAGSTAD. That is right.

Senator DONNELL. Doctor, on page 10 of your statement today, you have this to say:

> The American Dental Association is of the opinion a Federal grants-in-aid system to States for health programs is desirable and effective.

Now I ask you as distinguished from the association and referring now to your own personal opinion, do you concur in that opinion that a Federal grants-in-aid system to States for health programs is desirable and effective?

Dr. Flagstad. Yes; I do.

Senator Donnell. Now I call your attention to page 11 of your testimony where you say:

> The American Dental Association endorses the nonprofit voluntary prepayment plan for the distribution of health services—

and so forth.

Do you personally, as distinguished from the association, concur in the endorsement of the nonprofit voluntary prepayment plan for the distribution of health services?

Dr. Flagstad. Yes. Unfortunately, in dentistry, it has been very difficult to set up, and we have not made the progress we should like to have made. I think you have had testimony from the Medical Association indicating that it is operating quite successfully in medicine in many sections of the country.

Senator Donnell. But both you personally and the American Dental Association do endorse the nonprofit voluntary prepayment plan for the distribution of health services?

Dr. Flagstad. Yes, sir; and we are on record.

Senator Donnell. And it is your present view today just as much as it has been in the past. Is that right?

Dr. Flagstad. Yes; that is right.

Senator Donnell. Now Doctor, referring to your testimony of last year when you were here, Senator Smith this morning raised the question whether you think it is advisable to put into effect the national system all at once or whether you favor what he has more than once referred to here and elsewhere as the guinea pig experimental type of approach. Now I call to your attention this language in your testimony of last year which, as I understand it, you are in accord exactly with what you said this morning.

On page 1020, you say:

> The American Dental Association believes that compulsory health insurance for a majority of the population should not be established in this country without preliminary scientific experimentation involving less extensive groups of the population.

Now do you still adhere to that view that is expressed in your testimony of last year, both you personally and the American Dental Association, so far as you know?

Dr. Flagstad. Yes, sir.

Senator Donnell. Now in your testimony of last year, on the same page, you say this:

> The American Dental Association believes that the grants-in-aid system has been effective in meeting certain health needs under the Social Security Act. The American Dental Association believes that this system should be enlarged to meet all health needs and that there is no necessity for enacting a national compulsory prepayment plan.

Do you still adhere to that viewpoint personally?

Dr. Flagstad. Yes, sir. That is the same as in our present statement.

Senator DONNELL. That is the same as is quoted identically in your statement today. Doctor, I think it was Patrick Henry that said something about he knew of no better lamp to guide one's feet than that of experience.

I ask you in referring to your testimony of last year whether you in any sense have changed your view as expressed on page 1022, which is as follows:

> Experience in foreign countries reveals that effective dental health programs have not been developed under the compulsory health insurance system.

Do you still adhere to that view?

Dr. FLAGSTAD. Yes, we do; and further studies have been made and we have further evidence to substantiate that statement.

Senator DONNELL. Now, in your testimony last year, you elaborated somewhat on that statement and you said this, and I want you to listen to this, please, and tell us whether or not you still adhere to this view on page 1023:

> The following short quotations are taken from the report of an official committee of Parliament appointed to study the British dental program:
>
> "Roughly two-thirds of the insured population, that is between 13 and 14 million people, are entitled to dental benefit, but only 800,000 (less than 7 percent) of these claim it on an average each year."
>
> It is the contention of the American Dental Association that there is something intrinsically wrong with a program which compels 13 or 14 million people to contribute for a service which only 800,000 receive.
>
> Another quotation from the committee's report:
>
> "The state of the dental health of our population, "that is the British population, I take it, "and its effect on their general health is bad." Then you continue with your own statement of last year:
>
> The American Dental Association does not believe that any program which must make such an admission after several decades of existence gives any indication that it will aid in rearing a generation of adults less afflicted with dental disease.
>
> Perhaps it might be impressive to add the general opinion expressed by our veterans of the Dental Corps stationed in England during the war. Their opinion is: "the dental health of the people of England is very poor and so is their dentistry."

Do you still adhere, Doctor, to those quotations which I have read from your testimony of last year?

Dr. FLAGSTAD. Yes, sir, Senator.

Senator DONNELL. Now Doctor, I call to your attention the book by Mr. Hermann Levy. You are familiar with that book, are you not, on national health insurance?

Dr. FLAGSTAD. I am not.

Senator DONNELL. For the purpose of the record, I would like to read one sentence from page 154 of this book. This is published under the University Press of Cambridge—that is English Cambridge 1944, and reads as follows. This is under the heading of Dental and Ophthalmic Service:

> Less than 10 percent of the insured population eligible for dental benefits applied for them in any year.

Now that seems to corroborate your general statistics that is set forth in your testimony of last year. And you still adhere to the same observations with respect to experience?

Dr. FLAGSTAD. Yes, sir, Senator.

Senator DONNELL. And you put a value likewise obviously on experience in determining whether or not national compulsory heath insurance is advisable?

Dr. FLAGSTAD. Yes, sir.

Senator DONNELL. Now, Doctor, I call also to your attention this statement which appears in your testimony of last year on page 1024:

> This series—

that is the series of advantages of the legislation which your association has proposed over the bill S. 1606 of last year, of which S. 1320 is a lineal descendant, I should say, having many characteristics of its parents, grandparents, and great-grandparents—

> could be continued at great length, but I believe the point has been made; the American Dental Association is opposed to the enactment of S. 1606 because it is not good legislation for improving dental health.

Do you still adhere to that view, Doctor?

Dr. FLAGSTAD. Yes; I do.

Senator DONNELL. Last year we had the benefit of Dr. Gruebbel. You presented Dr. Gruebbel, I think, did you not, last year?

Dr. FLAGSTAD. Yes; we did.

Senator DONNELL. Would you mind stating just who Dr. Gruebbel is?

Dr. FLAGSTAD. He is the secretary to the council on dental health in the American Dental Association. He is a full-time employee of the American Dental Association and makes it his business of studying the dental health situation and helping with the development of dental health programs throughout the United States.

Senator DONNELL. Now, bearing in mind the question propounded to you a little while ago by Senator Smith on the advisability, on the one hand, of the inauguration of a vast national system or, on the other hand, a community experiment, I read to you this portion of a paragraph from Dr. Gruebbel's testimony last year on page 1027 and ask you whether you concur in the views expressed by him. He is referring here to Senate bill 1099. He says:

> It is primarily a grant-in-aid bill to provide dental services on an experimental basis on a community level. We believe that past experience shows that such programs, developed on a community basis and designed to meet the need in the community itself, can be very effective. We do not believe that there is any evidence to show that a compulsory health system will do that, because the conditions in the various communities are so different. You cannot, in our estimation, have one blanket program on a national basis which will fit every community, because the circumstances and needs are so very different in the various communities.

Do you concur, Doctor, in this statement of Dr. Gruebbel's of last year?

Dr. FLAGSTAD. I do; and I have practically said that in answer to Senator Murray's question.

Senator DONNELL. Now, I have only one or two other questions, and they are these. Last year you called upon the editor of the American Dental Association Journal, Dr. Harold Hillenbrand, to answer a certain question. Do you know Dr. Hillenbrand?

Dr. FLAGSTAD. Yes, sir. He is now general secretary of the American Dental Association.

Senator DONNELL. Now, he is a man of high standing, I judge, and has the confidence of the members of the dental profession?

Dr. FLAGSTAD. Yes, sir. He had the confidence of the dental profession to the extent of being elected their secretary. It is perhaps the most responsible position we have to offer in the dental association.

Senator Donnell. On page 1035 there was this question propounded to him. The question was:

> Dr. Hillenbrand, do you favor the following of a plan of national compulsory health insurance in the administration of dentistry throughout the country?

Dr. Hillenbrand replied, "No; I do not."

I will ask you whether or not you, Doctor, yourself, favor a plan of national compulsory health insurance in the administration of dentistry throughout the country?

Dr. Flagstad. I do not.

Senator Donnell. That is all.

Senator Smith. Senator Pepper?

Senator Murray. I would like to ask a few questions before I leave. Doctor, you say there is no better way to guide your feet than by the experience of the past. What is the experience of the past with reference to adequate dental care in this country without any programs?

Dr. Flagstad. The American Dental Association recognizes that there is not adequate dental care at the present time. Is that what you wish?

Senator Murray. Yes; and there is a very extreme deficiency of dental care in the country.

Dr. Flagstad. Yes, sir. I think we are all interested in the same problems to try to find a way to take care of this inadequacy.

Senator Murray. The lack of adequate dental care in this country has been so extreme that it would be impossible now to take care of the needs of the country with the present personnel of the dental profession, wouldn't it?

Dr. Flagstad. I think that is the feeling of the American Dental Association.

Senator Murray. Now, with reference to the nonprofit voluntary systems of medical care or dental care that is only in the stage of experiment at the present time, if it should develop that these voluntary systems will prove inadequate, then do you think some other method should be considered if, under the voluntary system, it is going to be impossible to provide adequate medical care? Would you think then some other method should be considered?

Dr. Flagstad. We believe, in addition to that, that other methods are necessary. We are particularly interested in the children, and it seems to us that the program offered by S. 545 makes an attack on the problem and we want to make it within the possibility of performance. That is why we are suggesting the amendment.

Senator Murray. What percent of Americans today are getting adequate dental care?

Dr. Flagstad. I couldn't say offhand. Perhaps Dr. Mead, the president of the American Dental Association, can answer that. We might state, Senator, that food and clothing are inadequate at the present time, too. It is a good comparison, and we have many methods of trying to provide adequate food and clothing but haven't discovered a satisfactory means, and the same thing is true of medical care.

Senator Murray. But in the case of dentistry, only a very small percentage of the total population are really getting adequate dental care. Is that right?

Dr. Flagstad. I think the statement is true to a degree as a considerable portion of the population is receiving adequate dental care.

Senator Murray. That was the same situation in England, was it not?

Dr. Flagstad. At the present time?

Senator Murray. Yes, and at all times in the past.

Dr. Flagstad. But they are not getting adequate care under the compulsory health insurance plan, either.

Senator Murray. Well, I am not dwelling on that at the moment. The past history in England has been that the people there failed to get any substantial degree of dental care. My understanding from reading is that in England 30 or 40 years ago, the people there, because of the absence of adequate dental care, were losing their teeth at an early age and the women of England at the age of 30 were without teeth, and that the situation there was appalling with reference to the lack not only of dental but medical care.

Dr. Flagstad. Compulsory health insurance has not improved it.

Senator Murray. Well, that remains to be seen. It has been in operation only a little while. Such a claim is made with reference to every compulsory system in the country. A doctor was here the other day and testified with reference to the deficiency of the compulsory system in New Zealand, and at the same time I was receiving letters from medical men in New Zealand claiming that the situation over there was vastly improved and that the medical profession there were becoming more satisfied with it, that every program of this kind in its initial stages develops deficiencies, but they claim that it is being improved upon and that no one in New Zealand today would desire to change the system.

Now I think that we should let those people develop their programs over there and find out later on, after it has been experimented with for a sufficient period of time, whether or not they constitute an adequate and effective method of handling the situation.

Dr. Flagstad. Personally, I am perfectly willing to let them experiment with it, but not in the United States.

Senator Murray. That is right. We all prefer that method. I would rather profit by the experience of somebody else in speculating or investing or carrying out any activity. If someone else is successful and it proves to be a correct method, why, then, of course, I would like to take advantage of that. I don't like to be so biased or opposed to anything that I wouldn't consider what people have done in other parts of the world, and I am sure that Dr. Flagstad, who has testified here before so ably, will agree with me that we should not close our minds to any change.

Dr. Flagstad. I don't believe the American Dental Association will close its mind. If experiment shows that a program is desirable and effective, the American Dental Association has always changed its point of view in connection with it, but it has to be pretty clearly demonstrated it's a good procedure for the public welfare.

Senator Murray. I understand that as a result of the inadequacy of the medical and dental care in England, they found over there that it was absolutely necessary to adopt some other plan, and they have adopted the compulsory system over there and are trying to work it out, and they are trying to do the same thing in other parts of the world. They are in the stages of experimentation, yet in many of those sections of the world, and I think that we should profit by their experience.

I am very sorry, Doctor, that I can't remain any longer at the present time. I am due at a conference and I must leave at the moment, and I am sorry I can't be here to hear Dr. Mead's testimony.

Senator DONNELL. Mr. Chairman, if the Senator might stay for just a moment. In regard to this matter of national compulsory health insurance, I understand, Doctor, that you are not recognizing the difficulty of looking into the future. Your note this morning prophesies national health insurance as the answer to the dental health problem.

Dr. FLAGSTAD. Not at the present time. I can't talk about the future; none of us can.

Senator DONNELL. Referring to New Zealand. I have in my hand here the book Relief and Social Security by Mr. Lewis Meriam issued under date of 1946, and I just call to your attention this language on page 548:

> The New York Times of October 7, 1945, reported that the Minister of Health of New Zealand stated in the House of Representatives that because of abuses, the Government is seriously considering whether free physician services will be continued. It admits widespread racketeering which followed the institution of a system under which a New Zealander may consult a physician as frequently as he likes and the doctor can collect a fee for each visit. The costs are running far higher than the Government anticipated when it instituted the system, and they constitute a serious drain on the social-security funds. Placing physicians on salary is one of the possibilities under consideration.

Now, looking back through the spectacles of today over experience, I take it that none of us would regard that type of testimony as affirmatively in favor of the success of the operation of compulsory health insurance in New Zealand, would we, Doctor?

Dr. FLAGSTAD. No.

Senator DONNELL. You wouldn't regard that as evidence in favor of our country embarking on national health insurance, would you, or compulsory health?

Dr. FLAGSTAD. I heard a report some years ago by the medical men who made a survey of the situation, and their report was not favorable.

Senator DONNELL. That is in New Zealand.

Dr. FLAGSTAD. Yes.

Senator DONNELL. Of the situation in New Zealand.

Dr. FLAGSTAD. Yes.

Senator MURRAY. Before you leave that, Senator, would you give us the date of that?

Senator DONNELL. 1946 is the date of the book, and the article is the New York Times article of October 7, 1945, and, as I recall it, and I will introduce it into the record a little later, last year we had one or two New York Times articles, I think, bearing on this subject.

Senator MURRAY. Of course, other books are being written right along. There is a book now in process of publication, the book by Dr. Blanc, Money, Medicine, and the Masses, which will be published in a very short time, which takes an entirely different view than the book that you have there of the date 1946. So that the matter is being studied and is being written about. It is being debated and, as I understand in a statement a moment ago, the people of that country, the medical profession of that country, would not think of having it repealed.

Senator Donnell. At any rate, the time between 1946 and 1947 is not very extensive, is it Doctor, to involve a total reversal in the success or lack of success in that country?

Nowfi may I call to your attention just one or two things. In the first place, New Zealand, as I understand, has a population of about 1,600,000, about the same as Colorado, consisting of a pastoral people very largely. There are no large cities there in New Zealand that you know of.

Dr. Flagstad. I am not familiar with New Zealand, Senator. I have heard of the country but have not been there.

Senator Donnell. At any rate, I haven't been there, either, and I don't know too much about it, but we certainly haven't heard of any large cities, and a population of 1,600,000 is not at all comparable with the widely varied circumstances which exist in the United States with 140,000,000 people. We all agree with that.

Dr. Flagstad. I would say the problem would be entirely different.

Senator Donnell. Entirely different; that it correct. That is all.

Senator Smith. Before I call on the next witness, I would like to ask Senator Pepper if he has some questions.

Senator Murray. Before you proceed, Senator Pepper, I would like to ask, Dr. Flagstad, do you know of any country which having adopted the compulsory system for the provision of various forms of medical care has ever repealed it?

Dr. Flagstad. I do not know of any, Senator. You can ask the president, Dr. Mead, that question and maybe he has further information on it.

Senator Pepper. Do you favor the insurance principle at all in respect to the provision of medical care?

Dr. Flagstad. Do you mean voluntary insurance?

Senator Pepper. Do you favor the insurance principle?

Dr. Flagstad. We favor the voluntary insurance principle.

Senator Pepper. You do think that the voluntary insurance principle as applied to the provision of medical care will give the people better service than they are able to obtain under a system where the voluntary insurance principle was not in effect?

Senator Donnell. Are you talking about dental——

Dr. Flagstad. Not necessarily, Senator; no.

Senator Pepper. But I thought you favored the voluntary insurance system.

Dr. Flagstad. We favor it but it does not mean that it gives them better care.

Senator Pepper. You do not think that it does?

Dr. Flagstad. Better than the present system? I think it might be financially easier for them to carry the load.

Senator Pepper. I believe you stated that there was a great inadequacy in dental care. To what do you attribute that, Dr. Flagstad?

Dr. Flagstad. I attribute that to a number of different things, not only to the fact that perhaps our manpower is low at the present time, but motivation is the thing. That is why we are in favor of dental health education. We stress that all through—to motivate the people.

Research is another thing that is essential, and you have been very kind on our bills in helping us with that particular phase. We believe that dental research will help us solve some of the problems of dental disease and eliminate some of them so we will have less to combat.

Those are the chief things, I think.

Senator PEPPER. You ignore lack of adequate benefit paid for the dental care needed?

Dr. FLAGSTAD. I think finances are a factor.

Senator PEPPER. You did not mention that at all. Would you say that is not a major factor?

Dr. FLAGSTAD. I would say "No." I would say it is a factor and that we hope with legislation to aid in overcoming that particular factor.

Senator PEPPER. Is it one of the major factors?

Dr. FLAGSTAD. I would not think so. We could ask the president, Dr. Mead, that question and see what he says.

Senator PEPPER. Do you favor, yourself, the means test in eligibility for dental care?

Dr. FLAGSTAD. It depends on what you mean by the means test. We believe that any determination of those who shall receive service, dental service, at the Government's expense, shall be made by the community or State, and that the methods should not be set by the Federal Government. We do believe that dental care should be limited to those who are unable to pay, as I said in my statement.

Senator PEPPER. Do you mean those who do not have the means to pay?

Dr. FLAGSTAD. If you want to put it that way, all right.

Senator PEPPER. Your attention was called to the resolution of your house of delegates where, as I understand it——

Dr. FLAGSTAD. I would rather leave that resolution to the president to explain, if you will ask him, Senator Pepper.

Senator PEPPER. Just one other question: Have you any recommendations? I believe you stated that the number of dentists existing at the present time in the country is inadequate to provide the people the dental care they need.

Dr. FLAGSTAD. I think that is true.

Senator PEPPER. Have you any plan to propose; do you consider that the Taft bill will meet that deficiency?

Dr. FLAGSTAD. I think the national health bill will help meet it.

Senator PEPPER. How?

Dr. FLAGSTAD. By making Federal money available as grants-in-aid to States to set up a dental-health program.

Senator PEPPER. You do not consider that they authorize the State to provide tuition and living expenses and other means that will make it possible for students to become dentists, do you?

Dr. FLAGSTAD. I do not quite understand the question.

Senator PEPPER. You stated that in your opinion the Taft bill would aid in making more dentists available to the country, and, so far as I know, the way you get dentists is for students to go to dental schools and become graduates and then go out and practice dentistry.

Dr. **Flagstad.** At the present time, Senator, we are having no trouble with dental students; our schools are over-flowed with dental students.

Senator **Pepper.** There are enough students in schools now so that when they graduate the number of dentists in the country will be adequate to give the people of the country the dental care they require?

Dr. **Flagstad.** I will say, "No," but I will say we will have very considerable more dentists than at present.

Senator **Pepper.** Undoubtedly we may have more, but, I think, are we not legitimately concerned with the question of the adequacy of the dentists to serve the dental needs of the country?

Dr. **Flagstad.** We are concerned with setting up a program which we are able to handle at the present time.

Senator **Pepper.** Does the Taft bill provide such a program?

Dr. **Flagstad.** We have offered amendments that we think will help it get some arrangements to give more adequate care, not completely adequate care for everybody.

Senator **Pepper.** Is there any reason why we cannot strive for a complete plan?

Dr. **Flagstad.** We are striving for it. That will be a start.

Senator **Pepper.** What is the necessity of limiting it to less than the number of dentists necessary to meet the dental needs of the country?

Dr. **Flagstad.** We only have certain facilities in school to produce men. You only have a certain number of schools and they can only produce so many dentists.

Senator **Pepper.** Does the Taft bill provide any plan for enlargement of the number of dental schools and the provision of more school facilities to the students of the country to take dental training?

Dr. **Flagstad.** No; but there are plans under way. The Taft bill does not attempt to attack that problem.

Senator **Pepper.** Have you any amendment to offer to solve it?

Dr. **Flagstad.** We have the amendment in the statement, Senator, the one before you.

Senator **Pepper.** Does it contemplate setting up more dental schools?

Dr. **Flagstad.** No; but it contemplates making the program possible within the manpower we have.

Senator **Pepper.** But I am interested in getting dentists. How are we going to get more dentists to furnish more dental care to the country?

Dr. **Flagstad.** Well, up until the time of the war, our schools were not overcrowded. At the present time the schools are filled to maximum and there have been new schools established. We hope that will help. We also have some auxiliary help.

Senator **Pepper.** I know; but what can we do or what do you propose doing to establish more schools and provide more dental training so there will be more dentists for the country?

Why should the country go along without its dental needs being met?

Dr. **Flagstad.** I think we are doing quite well; at least we are making progress. The American Dental Association is encouraging the establishment of dental schools where they are necessary. There are several that have been established within the last 2 years by act of legislature.

Senator PEPPER. Would you be willing to recommend, to formulate a program and submit it to the Congress as to how Congress could help and help the States and other political subdivisions in providing as many dental schools as might be required to turn out the number of dentists that the country might require?

Dr. FLAGSTAD. That would be a question for the American Dental Association's House of Delegates to determine.

We have in the American Dental Association a Council on Dental Education. The Council on Dental Education has that particular problem to deal with and the council is doing everything it possibly can to enlarge the dental educational facilities.

Senator PEPPER. You say, doing everything it can. Is it recommending how we might set up a Federal program to aid in the building of those schools, furnishing equipment to them and acquiring personnel and making scholarships and fellowships available to the students?

Has it done all that?

Dr. FLAGSTAD. I think they have approached the Federal Government for funds for improvements in schools through other organizations.

Senator PEPPER. That is all. Thank you.

Dr. FLAGSTAD. I think you would get a fuller answer from Dr. Mead, who is president of the American Dental Association. If you will ask him that question, he may be able to answer it even better than I.

Senator SMITH. We will ask Dr. Mead now to come to the witness chair.

## STATEMENT OF STERLING V. MEAD, D. D. S., PRESIDENT, AMERICAN DENTAL ASSOCIATION

Dr. MEAD. Thank you, Senator.

With your permission, I would like to present a prepared statement.

Senator SMITH. Will you give us a little biography, a little background, your experience, and so forth, that qualify you in these hearings?

Dr. MEAD. I am president of the American Dental Association. I am in the private practice of dentistry, an oral surgeon here in the District of Columbia.

Senator SMITH. How long have you been president of the association?

Dr. MEAD. I have been president of the association for 1 year; president-elect for 2 years. I was chairman of the legislative committee for a number of years and associated with various parts of the American Dental Association over a period of years in the District of Columbia Dental Society.

Senator SMITH. Where did you get your dental training?

Dr. MEAD. George Washington University.

Senator SMITH. Do you have a degree in dentistry?

Dr. MEAD. I do.

I would like to present this statement and not read it because I think I can save your time by making just a brief summary of it.

I do not believe it is necesary for me to go into the program of the American Dental Association because I know it has been ably presented by Dr. Flagstad, and I can refer you to the record of last year before the Senate, where we had very extensive hearings on various phases of our program of dental service and certain phases of this particular bill we are talking about.

We feel that dental research is not covered to the extent that it should be. That is a very integral part of our program.

We have presented to you, I think, very fine testimony about the necessity for dental research, because when you carry on dental research you will cut down the size and cost of our program. When you consider the number of dentists needed, and when you learn more about the specific causes of disease, you will cut down the size and cost of the program. We are more interested in that than anything else. It doesn't seem wise to be spending great effort on the repair of damaged tissue when you could well be studying the causes and control of disease.

Senator SMITH. Preventive rather than curative?

Dr. MEAD. That is right.

I think there is no different in philosophy about our research bill. I think everyone is well aware of the necessity and need for research.

I think our association, the American Dental Association, is in a very enviable position with its program because we adopted our principles a number of years ago and have advocated this program for a long time. We have appeared in the States and in Congress and we have repeatedly pressed our program.

We pressed for a program for a long time. We have had other research bills through the Senate that did not pass the House. It is not something new with us. We believe explicitly in our program.

We need something in addition to dental education and research. There is a problem of dental care and especially with children. The children's problem is the greatest we have today for they are the adults of tomorrow. If we do a fine children's program, we certainly will need all of our energy and resources. I would say it will be a very difficult matter even to do a very fine children's program. It will be an extensive program. I think we should concentrate upon it at this time for certainly anything that is good for a children's program will give you all of the data that you want for other programs.

Of course, there is necessity, as you proceed with a program, to take care of those who cannot afford to pay. There are people who are deserving. We have always had in our program the care of the people who are unable to pay. That is not anything new.

Now, our whole interest in the approach to this problem is getting additional funds to take care of those who cannot afford to pay.

We think, we realize that there are certain dangers in grants-in-aid; that it is not a Santa Claus proposition of just giving money to a State. The person who gets dental care free gets it at the expense of someone else. Somebody has to pay for it in one way or another; but we know of no better way to get the additional funds we need than grants-in-aid, even with some of its dangers.

Talking about this bill, we support this bill. There are certain amendments we think that can be made to great advantage. Anything that distributes the method of administration to the States or the communities is much better.

We are opposed to any plan that is carried on at a Federal level because that is where we get the bureaucrats and that is where you cannot set up the plan to meet the needs of the community.

In the tables I have presented to you here we will show the manpower, the number of dentists per capita, and the difference in need in different sections of the country.

In the Southeast section of the country there would have to be three times as many dentists or dental workers on a children's program as in the Eastern States. In the far West they have the best relationship of all.

So it is different in different sections of the country; different States, different communities.

I do not think this program we have advocated is revolutionary at all. It is sound. It has been tried. There is no great experiment about it. The only experiment is just how the method of administration of the program should be tried out.

We are definitely opposed to the Federal program because that is not experimental either. We have had plenty of experiment. There have been experiments in most of the foreign countries and we know what they have done. We have had experiments in our own military services.

We believe that any service administered at the Federal level and by the Federal Government is a bureaucratic system and compulsory in nature, and if you do not believe that, just consider for a moment the Army and Navy and Public Health. We have had plenty of experience with them. Take the services, especially before the war—the Public Health and the Army and Navy—did they not need a transfusion of those who came in to bring them up? Anyone who has been around and seen what service they had to do and so on will realize they have compulsion.

Certainly, dentistry did a good job in the war. Why should it not? They had 23,000 of the best dentists in the world and they were of the age group that could carry the burden but they worked in a very inefficient system with bureaucracy at best because you had others to fight their battles.

They have worked in the services without the control of their own activities, without the right of direct approach, without any morale. Morale today in the dental service is at its lowest ebb. The Army is probably worse in morale because many of the dentists want complete separation. They want to control their activities.

In the Navy there is also trouble. If you do not believe that, here is an interesting fact: There was an examination not long ago for dentists to fill 700 vacancies in the naval dental service. There was one application.

They now have an examination scheduled for more than 700 because a lot of dentists have resigned; and they have no applicants. The situation is far worse in the Army because it is twice as large.

We are not speaking about individual dentists in the services for they are our best friends and some of the best dentists are in the Army and Navy and Public Health, because if they are good there, they are better than somebody else. Their morale is low. They do not have opportunity. You take away initiative that they normally have in this competitive type of service. We cite that as compulsion. We have been fighting that system for years. It is getting to be a very hard and difficult one for us.

Now, for the grants-in-aid, we feel that the more leeway you give a State in the administration of its program, the better; some States will be able to set up a good children's program much quicker than other States because of the manpower, because of certain conditions. It will vary in different localities. We feel there should be provision for dental health education and we feel that they should have as much control of their activities as possible.

The question was brought up about a means test. Well, that is a little difficult because it is according to what you mean by a means test. There are various definitions. What we all mean is a method of determination of who is able to pay.

I am confident and I feel that the American Dental Association does not want to give dentistry free to those who can afford to pay and any statement to the contrary is confusion.

The American Dental Association does not want the means test administered at national level, just like they do not want a program administered at the national level because they feel what is good for one State and community is not good for another, but they want a method of determination at State level. They want a test of some kind but they want the State to determine what the test will be—whether they will just simply ask the individual whether he has the money or whether the principal of the school determines the method, or how it is determined. That should be entirely left to the State.

Now, as far as the administration of the program is concerned, our association, I think, has believed for a number of years that it would be well to have, Senator, all the activities of dental health and medical health service in one place; we would like to have a departmental status and we think that should be administered by somebody who knows health service, and if it is to be administered in the Public Health Service, we think that they should have control over their activities and not be controlled by social security; but we are with the plan of centralization of the health services and preferably with Cabinet status.

Senator SMITH. I might ask this, Doctor. I have been advised that S. 140 contemplates a so-called Department of Security, with a Cabinet officer and an Under Secretary of Health, Under Secretary of Education, and Under Secretary of Welfare. The Under Secretaries are not required to be professionally qualified, apparently, in their respective fields; that would not quite meet what you have in mind?

Dr. MEAD. We would prefer to have the health service separated from any other service. It is a big enough problem and we think that it would be better to have it separate. It should be separate.

Senator SMITH. We are not discussing that bill; that bill is not before us; but I am very glad to get your own judgment on that particular point.

Now, I gather from your testimony here and from these tables that you do not feel too hopeless with regard to your present supply of dentists to take care of these needs?

I was rather appalled by the figures that Dr. Flagstad gave us and brought out in my question to him the fact that there are apparently 78,000 registered dentists in the United States and 140,000,000 people. It seems to me like a terrific load on each one of 78,000 dentists if they are going to do anything in the way of an over-all program.

I would like just a little comment from you along the line of Senator Pepper's question as to what you have in mind as an association for developing more dentists by educational program or something of that kind, or inducements?

Dr. Mead. Senator, I think there is a lot of confusion. There is even a difference of opinion as to whether you have a shortage of dentists.

If the American Dental Association plan is carried out we may or may not have a shortage of dentists and we will probably not have. It is not a question of dental schools. If you had 10 times the number of dentists in dental schools you have today, that would not necessarily solve a shortage of dentists, if there is a shortage of dentists, because there is more to the problem.

It is a problem of unattractive and uneconomic areas. Do you think that a graduate of a dental school will go to one of these areas because there is a need there and we want to send him there? He is going to go where the field seems most attractive to him. He is very apt to go to the metropolitan centers and areas. The first thing you know, there will be too many of them in such an area and some of them will go hungry and when they do, they might go to these uneconomic areas, anywhere where they can make a living.

Now, there has been discussion in the past—I think I talked to Senator Pepper one time before—one of his own constituents brought this up and Dr. Ostrow brought this up—there are a lot of poor boys that cannot afford to go into dentistry. We are as anxious to educate as many dentists as possible. But you cannot send them to certain areas just because you need them. Possibly some of these areas might think of some plan of a subsidy to educate a dentist with the provision that he comes back and practices in that community a certain length of time. There are other things to be thought of but I think the importance of the program is so great that we should center our activities upon improving the dental health of the Nation at this time and especially a children's program and not get too far out on the limb about the shortage of dentists.

Now, another thing that should not be forgotten, the most important factor of all is the research; if you cut down the size of your program, if the experiments on fluorine should prove to be as valuable as thought by a great many, then you would not need the great number of dentists, you see it will either cut down the size of the program or it will not be along the line we think.

I do not think I should discuss flourine but if you want to ask me any questions about it I will be glad to answer or to discuss it.

Senator Smith. I do not think we need go into that at this moment.

Your suggestion in your statement as I interpret it is that if we develop research in the field of prevention you are not going to have problems that are present when children come along and finally get into difficulties and in old age really bad difficulties; that is where we get hold of the need.

Dr. Mead. That is right, something more important than the shortage of dentists at the present time.

Senator SMITH. You are primarily interested in preventive research?

Dr. MEAD. Yes; and care of the groups of those who most need it, especially children.

Now, when we talk about these programs, we are advocating a program that is not experimental. We have excellent examples of what we are advocating in practice now. You have in the District of Columbia, a very fine program for children conducted by Dr. Ostrow under the Health Service of the District. You know the population of the District is larger than that of at least 14 States and the problems are just as difficult from many angles as anywhere else; still every child is getting a free dental examination once a year and those who cannot afford to pay go to clinics. There are 12 clinics for them, they get dental service and it is being carried on wisely and economically. They could use more money to expand it but it is a good program. We have other good programs in other sections of the country. We want to extend them. If we extend the good programs that we know to be good and they exist today and are proved good, everywhere, then you would not have the shortage of dentists that we speak of. When you say that dentistry is bad, dentistry in the United States is the best in the world. It is so recognized.

We have more dentists per capita than anywhere else in the United States but still, as I say, we are in a very enviable position because we advocate good dentistry and it is not poor dentistry that is valuable.

You must carry the standards of dentistry and keep them high or dentistry is not going to be worth anything.

Senator SMITH. You have those established State by State or would you have them established nationally?

Dr. MEAD. We have it State by State.

Senator SMITH. You prefer the State-by-State method?

Dr. MEAD. Yes; we believe in the State plans.

Senator SMITH. So you get constantly benefiting experience from what you may call 48 laboratories at work in this field to determine what is the best way to determine this problem.

I think I will ask Senator Pepper and Senator Donnell if they have questions.

Senator PEPPER. Dr. Mead, I thoroughly subscribe to all you said about encouraging research, and you no doubt know that our dental research bill was approved by this subcommittee and is now before the full committee for consideration. So we all want to push research; and then, of course, dental research would be a part of medical research under the National Science Foundation bill.

Senator DONNELL. Off the record.

(Discussion off the record.)

Senator SMITH. On the record.

Dr. MEAD. May I add one thought in case I do not think of it later.

In the consideration of the grants-in-aid to States, it may be very well to consider as much leeway to the States in setting up their program as is possible, as I have already suggested. That is from age limits also. In some localities they may want to take care of preschool children from 3 years on up because after all it is far less expensive for dental care all the way through than it is to allow disease to occur and then correct it.

They may want to take care of high-school and preage, all the way through. A State may be in a position to handle that because of numbers of dentists and the problems of the type of dental service they have to do. Other States may not be able to do that. So there ought to be some plan to allow a State to determine the numbers, the age limits to which they will go in the administration of a plan for dental health care under the grants-in-aid system.

Senator PEPPER. Dr. Mead, the American Dental Association favors S. 176, does it not, and you favored it last year?

Dr. MEAD. That is the research bill. That is correct, sir.

Senator PEPPER. You do favor it; last year you testified before the committee; the committee recommended it and the Senate passed it.

Dr. MEAD. We presented that bill.

Senator PEPPER. That was your bill; that is correct. Your bill and offered at your instance last year.

Now. that pertains to research. As I say, I am at least in favor of that bill.

The next question, then, is the provision of dental care; and that is a matter of course about which there may be differences of opinion, a different theory being involved in the Taft bill than in the Murray bill.

Dr. Mead, it is a fact, is it not, as disclosed in the report of our subcommittee in January 1945, the Army dental program for the years 1941–43, handled 14,600,000 cases, had 5,000,000 sittings; 3,000,000 fittings; 1,400,000 bridges and dentures; 196,000 dentures repaired and 6,000,000 teeth replaced. So far as you know those figures are correct?

Dr. MEAD. I do not know a thing about the figures, Senator.

Senator PEPPER. At least the Army did carry out a very large dental program during the period of the war?

Dr. MEAD. I stated, Senator, that they did a very fine job. Why shouldn't they?

Senator PEPPER. Then that might support the inference, might it not, that when dental care is available without cost to a large number of people that a larger number of people will take advantage of it and would take advantage of it than if they had to pay for it; and the provision of dental care by the Army met the financial question of the ability to pay for it which is covered with respect to the population getting dental care.

Dr. MEAD. I do not believe that; the American Dental Association is unalterably opposed to that viewpoint. All you have to do is talk to the soldier, sailor, or marine who received the treatment and that speaks for itself, and also where you have experimental plans. I think that even experimental plans that they set up in States where they give free dentistry to those who can afford to pay are not experimental because that is a question you cannot settle in a month or a year, because if anybody can get free dentistry and fine dentistry, if they pick out the men that are capable and have all the zeal and training and the best training and you can get that service and get it for nothing, that service will deteriorate in time. If you get people in that sort of plan you will have it go down so you will have a very inferior type of service. That cannot be proved in a short time.

Senator PEPPER. Now, Doctor, the provision of dental and medical care in time of peace would actually be the sort of system that they have in the Socialist countries or in the Communist countries and that would be literally socialized medicine.

Neither the Taft bill nor the Murray bill makes that approach to the problem except that in the Taft bill the money is appropriated and the service is made available to those who meet the test of need. It is an outright contribution, is it not, insofar as the patient is not able to pay for the services given?

Dr. MEAD. You are talking about the grants-in-aid at the present time?

Senator PEPPER. That is right.

Dr. MEAD. The grants-in-aid principle is something we presented ourselves and we are interested in our own philosophy and our plan where it is acceptable to others; we feel that we have the right approach to that.

Senator PEPPER. So the question that we are concerned with is how to get over the hurdle of inability on the part of the whole people to pay for the dental care they need. That is a problem we are wrestling with primarily, is it not?

We are interested in that problem, and the Taft bill approaches it from the grants-in-aid principle which involves the determination of ability to pay on the part of these persons receiving the service whereas the Murray bill approaches it from the principle of requiring a periodic and percentage prepayment of a person's income up to $300 a month and that is the compulsory prepayment plan based on percentage of the citizens' income, whereas the Taft bill favors the grants-in-aid principle with determination of ability to pay on the part of the person for service. Those are the two approaches, primarily, to the problem.

Dr. MEAD. I would not say that. I am confused because when you talk about the Murray bill you are talking about the Murray grants-in-aid bill or about the association with the so-called compulsory type of bill.

Senator PEPPER. I am saying that primarily the Murray bill provides the——

Dr. MEAD. There are two Murray bills.

Senator PEPPER. Well, I am talking about the last Murray bill that was introduced in the Senate.

Senator SMITH. You are not referring to S. 176?

Senator PEPPER. Oh, I beg your pardon; I am not talking about S. 176.

Senator SMITH. The Murray-Wagner-Dingell bill.

Senator PEPPER. I am talking about the honorable successor.

Now, Doctor, the Taft bill contemplates and requires the means test in the determination of ability to pay for the service given, does it not?

Dr. MEAD. It requires a method of determination at State level.

Senator PEPPER. Now, getting back to the question of provision of dentists, assuming that research does not disclose the fact that we will not need dentists because the people will be in such good condition that you do not need dentists—asuming you need dentists, then would it not be in the public interest to try to formulate some program to provide the number of dentists that the people do need in the country?

Dr. MEAD. I think we already have that.

Senator PEPPER. You think we have enough dentists at the present time?

Dr. MEAD. I did not quite say it that way, Senator, but I do not think it is the question of shortage of dentists but if we carry out the program I think we have a very fine approach to the program all the way along, cutting down the size of the program and caring for that group of the population that will be most effective—for the children, especially, and concentrating the efforts on the schools that now exist for as many dentists as they can handle.

We have a good experimental approach, at least, whether or not there is a shortage of dentists.

Senator PEPPER. Doctor, I consider the dentist so important that I would like everybody in the United States who needs dental care to be able to get it. Is that not an objective about which we might agree?

Dr. MEAD. We have always stated that as our objective, Senator.

Senator PEPPER. Then the question to be determined is, What plan will meet that objective? If we determine to make dental care available to all the people of this country, do we not have to consider when we are regarding such plans, the adequacy of a given plan, that is, whether or not it will accomplish the objective?

Now, do you think the voluntary insurance plans—let me start from here—do you think that the private-fee-for-service system for dental care, regardless of any of the voluntary insurance plans, and regardless of any compulsory insurance plan will adequately buy dental care for the people of this country according to need?

Dr. MEAD. It gives the best dental service in the world, and with the additions we have already named. As I said at the hearing last year, I heard no testimony that showed any other approach that would be as satisfactory as our plan.

Senator PEPPER. Are we satisfied in our country just to give other people more dental care than others have regardless of the inadequacy of the need?

Dr. MEAD. No, Senator.

Senator PEPPER. Do you favor the voluntary insurance plan or principle in respect to dental care?

Dr. MEAD. Yes.

Senator PEPPER. Has the American Dental Association worked out any of these voluntary plans the way the American Medical Association has?

Dr. MEAD. Dr. Flagstad answered that question for you by saying that the dentistry problem is different. We have approached the problem as near as you can. But when you get into a dental problem you do get into a different problem. Dental health service and medical health service are two different things.

Senator PEPPER. I ask you as a question of fact because I do not have information on the subject: Are there any voluntary insurance plans to the people of this country with respect to the provision of dental care as there are plans to provide hospital care and surgical care?

Dr. MEAD. Yes; we have some industry plans and we have some experimental plans.

Senator PEPPER. Where are they and how many people are covered?

Dr. MEAD. There is one in Louisiana and I do not know where the other is.

Senator PEPPER. Do you know how many people are covered?

Dr. MEAD. I do not know, Senator. We do not feel too hopeful about that phase of dentistry.

Senator PEPPER. The Blue Cross plans do not cover dental cases in any aspects?

Dr. MEAD. Yes; there are some States that have legislation for that provision but the dental problem is different and we are not too hopeful about that. That is why we have suggested our plan; we think it is better than that.

Senator PEPPER. What is your approach?

Dr. MEAD. Our approach is dental education, research, and grants-in-aid to extend the program, and primarily an extensive program for children.

Senator PEPPER. Grants-in-aid—you mean such as is contemplated by this bill to provide by Federal or State gift——

Dr. MEAD. Matching State funds.

Senator PEPPER. Well, Doctor, do you think that those grants-in-aid will be able to make up the difference between the ability of the people to pay for the care they need and the total cost of it?

Dr. MEAD. I do not know that I understand you.

Senator PEPPER. I am starting off with the thesis that I think it is legitimate to consider a plan that will meet the need of the people of the country for dental care.

Now your proposal is dental research, which I favor and dental education, which I favor; but now we get down to the question of meeting the needs of the people of the country—now you say your program for that is grants-in-aid, and I ask, Have you calculated the amounts of grants-in-aid that will be necessary to meet the needs of the country above the ability of the people to pay for the service?

Dr. MEAD. Yes, Senator.

Senator PEPPER. How much will it be?

Dr. MEAD. And if it is anything like I think it is, there is danger of too much grants-in-aid because your own Surgeon General came before your committee last year and testified that he only wanted the amount shown in the bill at that time. That is not as great as you have at the present time, because he said he could not administer that program, intelligently, with——

Senator PEPPER. I wish to ask you and want the record to show what request for grants-in-aid to meet the dental needs of the people of this country above their ability to pay for it is requested by the American Dental Association.

Dr. MEAD. How are you going to determine that ability to pay?

Senator PEPPER. That is a question for you folks; you are going to have to wrestle with that to determine who applies the means test.

Dr. MEAD. Do you not think the States or localities?

Senator PEPPER. Is it a secret? It seems everybody is going to leave it to the States. But what I am getting at is whether we are going to try to meet the dental needs of the people of this country and pay for dental care according to ability, assuming there is a great gap between ability to pay for it and the total need of the country.

Now, you say you are going to meet that by grants-in-aid program and I am asking you, have you made any calculation as to how much of a grant-in-aid you are going to have to ask for if you are going to do it that way?

Dr. MEAD. I think there are a lot of statistics as to the amount involved. We have a number of programs that are working well and I named one. We have one here in the District of Columbia and we have that program. That is working.

Senator PEPPER. That only applies to children.

Dr. MEAD. That applies to children, but we can tell what the adult problem will be by the children's program because if it is a good program for children, it is going to be a good program for adults.

Senator PEPPER. The reason I asked that question is that it is pertinent to this whole inquiry and this is just one aspect of it. It seems to me that the proponents of the Taft bill are faced with this dilemma: They have either got to admit that the plan offered in the Taft bill is not going to meet the total need of the people in the country and leave a gap unfilled or they have to face squarely how much the cost in Federal grants is going to be to meet the needs by the Federal-aid plan. If that alternative is considered, then we are entitled to know how much money is going to be involved, and I think it is generally agreed that it will be in the billions of dollars.

Now, the reason I bring this up is that the Murray bill—and I am speaking now of the honorable successor to the former bill, which carries on the glorious tradition of the former—but I will say that bill contemplates a large, a very large sum of money, because it provides compulsory insurance and requires each person covered—which runs way up around 100,000,000 people, or something like that—to contribute a given percentage. The employee would put up 1½ percent of his income up to $300 a month. The employer would put up 1½ percent of that income, that pay roll, and the self-insured would put up 3 percent of his income up to $3,600 a year. That is estimated to provide several millions, several billions of dollars, a very large sum, and the bill contemplates Federal grants to make up for the deficiency.

The definite amount of revenue raised by that compulsory requirement of prepayment and the total cost of the program considered here the Murray bill faces squarely the financial problem involved in furnishing complete medical care. Now, in the Taft bill they start off with a declaration at the front that it is going to give everybody—at least, it would lead anyone to the opinion that they are going to give everybody—it says it is the policy—it may only be a declaration—but what would you thing if you were reading this bill as a layman?—that it is the policy of the United States to aid the States through consultative service and grants-in-aid to make available medical, hospital, dental, and public-health services to every individual, regardless of race or economic status. What if you were a layman reading that? What would be the impression that you would get? Would you not believe that bill was designed to afford necessary medical, hospital, and dental care to all the people in this country? You see what I am getting at? That is the reason I asked you the question that if you take the dental needs of the people of this country and then deduct from those needs the ability of the people to pay for those needs, whether you would have a big problem, and if you were to meet that by the grants-in-aid principle, would it not require a very large sum of money?

Dr. MEAD. Senator, of course we have two conflicting philosophies. Our philosophy is different from that expressed in the compulsory bill because we do not believe it is just a question of the amount of service. We believe it is a question of quality of service. It is not how much service you do, but it is how much good service you do. We feel that we are in a position to know what type of service will best cut the size of the problem and produce the results we want. We feel that a compulsory system will give an inferior type of service to the kind we asked for. We believe at all times that anyone who needs dental service and is not able to pay for it should have it provided, by family, by community, by State and the Nation at large.

I believe that we have facilities with the grants-in-aid plan so that we can intelligently take care of—we could make a great step forward without breaking down the type of service we have.

Senator PEPPER. Doctor, just a last comment.

You say that while the Murray approach in respect to compulsory insurance and Federal subsidy to meet the deficiency might get over one of the hurdles to adequate medical care in all of its aspects, it would have certain disadvantages, one of which is that it would require a certain amount of central direction—although the later bill has tried to eliminate a lot of that—that is probably due to the great volume of service that would be required, it would tend to deteriorate the service and that it would be a great and colossal system that would present difficulties of administration. Those are perfectly valid and perfectly legitimate arguments to be made against it. The proponents of it would claim for it that it gets over the big hurdle. It gets over the question of providing the money for the care required and that while these other problems would exist they would have to be dealt with and they would be formidable but they would be not incapable of being met from time to time but from the viewpoint of the citizen; it is a matter of which method should be employed.

You are not a Communist or a Socialist if you advocate the Murray bill; you are not a criminal of any kind regardless of social interest if you advocate another approach. It is a question of which will get the best results in the long run and render the greatest public service. That is what is essentially involved in this decision.

You think for the time being that it would be better to follow the Taft approach.

Thank you very much.

Senator SMITH. Senator Donnell, do you want to ask some questions.

Senator DONNELL. Yes, sir; I would like to ask the doctor some questions.

Doctor, Senator Pepper dwelt on the tremendous amount that is involved in the plan of the Taft bill and expressed the view that it would mean billions of dollars to carry out the plan. It is suggested on page 2 in the language that—

> It is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status.

I take it, Doctor, that you have read in that connection page 18 of this bill, S. 545, which clearly shows that the State-wide program is designed and calculated to provide hospital services, surgical services, and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such.

The point I am getting at, Doctor, is that obviously the Taft bill does not in any sense intend to provide medical, hospital, dental, and public-health services to every individual in the United States; it has no such interpretation. I cannot see how it is possible even to indicate the possibility of that intention in the bill. It is limited, as indicated here, to meeting a gap between the provision that is made by voluntary efforts today and the provision that would be necessary in order to include persons having insufficient income with the services that are contemplated.

Now, so far as the cost element is concerned, Doctor, at this time I would like to introduce in the record here two things. In the first place, the suggestion, which I take it we can corroborate by additional testimony, is that this Murray bill, S. 1320, is only a part of a comprehensive social plan which would lead to vast expenditures of money for so-called social insurance, and I offer into the record at this time from the book by Lewis Meriam, Relief and Social Security, the table appearing at pages 671 and 672 of that book, entitled "Estimates of What Comprehensive Social Insurance Would Have Cost in 1940 According to Different Assumptions," and I call attention to the fact that the estimated cost of all these various benefits, not solely medical care, not solely that but all the total comprehensive social insurance, is estimated in three columns; one on low benefits, $7,566,000,000; the moderate benefits, $10,936,000,000; high benefits, $16,800,000,000; and at the bottom of page 671 of the work it is pointed out that with no means test, medical care on present levels of $23.58 per căpita annually would, in the column entitled "Low Benefits," amount to $3,105,000,000. I ask that the entire table be set forth in the record, Mr. Chairman.

Senator Smith. It will so be done.

(The table referred to is as follows:)

*Estimates of what comprehensive social insurance would have cost in 1940 according to different assumptions*

[In millions of dollars]

| Contingency and condition | Estimated cost | | |
|---|---|---|---|
| | Low benefits | Moderate benefits | High benefits |
| 1. No means test, old-age benefit payable on or after age 65: | | | |
| Average benefit $25 per month, assuming 67 percent retired | 1,825 | | |
| Average benefit $30 per month, assuming 78 percent retired | | 2,535 | |
| Average benefit $40 per month, assuming 87 percent retired | | | 3,749 |
| 2. Means test, child allowances for children under 18: | | | |
| Average benefit $10 a month, paid to 5 percent of children | 240 | | |
| Average benefit $15 a month, paid to 10 percent of children | | 720 | |
| Average benefit $20 a month, paid to 20 percent of children | | | 1,920 |
| 3. No means test benefit to single, widowed, divorced, or separated women not in labor market, 50 to 64 years of age, with or without children under 18: | | | |
| Average benefit $20 a month, low estimate as to number separated | 432 | | |
| Average benefit $25 a month, middle estimate as to number separated | | 555 | |
| Average benefit $30 a month, higher estimate as to number separated | | | 684 |

*Estimates of what comprehensive social insurance would have cost in 1940 according to different assumption*—Continued

[In millions of dollars]

| Contingency and condition | Estimated cost | | |
|---|---|---|---|
| | Low benefits | Moderate benefits | High benefits |
| 4. No means test benefit to widowed, divorced, or separated women, 15 to 49 years of age, with children under 18 years of age: | | | |
| Average benefit of $20 a month, low estimate of number separated and number with children under 18 | 305 | | |
| Average benefit of $25 a month, middle estimate of number separated and number with children under 18 | | 457 | |
| Average benefit of $30 a month, higher estimate of number separated and number with children under 18 | | | 64 |
| 5. No-means test benefit for males under 65 unable to work: | | | |
| Average benefit of $25 a month | 558 | | |
| Average benefit of $30 a month | | 669 | |
| Average benefit of $40 a month | | | 892 |
| 6. No-means test benefit for females under 50 years of age unable to work: | | | |
| Average benefit of $25 a month | 187 | | |
| Average benefit of $30 a month | | 224 | |
| Average benefit of $40 a month | | | 299 |
| 7. No-means test, medical care: | | | |
| Present levels ($23.58 per capita annually) | 3,105 | | |
| Levels of families with income of $3,000 to $5,000 ($28.52 per capita annually) | | 3,756 | |
| Adequate ($36 pre capita annually) | | | 4,741 |
| 8. No-means test, maternity benefit: | | | |
| Benefit of $25 for the period | 59 | | |
| Benefit of $37.50 for the period | | 89 | |
| Benefit of $50 for the period | | | 118 |
| 9. No-means test, funeral benefit: | | | |
| Adults, $80; 10 to 19 years, $60; 3 to 9, $40; under 3, $24 | 105 | | |
| Midway between 1 and 3 | | 131 | |
| Adults, $120; 10 to 19 years, $90; 3 to 9, $60; and under 3, $36 | | | 157 |
| 10. No-means test, unemployment premiums: | | | |
| Average weekly benefit $9.62 to provide for equivalent of annual average of 1.5 millions unemployed and on benefit throughout year | 750 | | |
| Average weekly benefit of $17.31 to provide for equivalent of annual average of 2,000,000 unemployed and on benefit throughout year | | 1,800 | |
| Average weekly benefit of $23.08 to provide for equivalent of annual average of 3,000,000 unemployed and on benefit throughout year | | | 3,600 |
| Total | 7,566 | 10,936 | 16,800 |

Senator DONNELL. Doctor, I wanted to ask you also in regard to the experience of foreign countries. I think you referred to that. Were you engaged in dental work during the war for the Government in any capacity?

Dr. MEAD. No.

Senator DONNELL. You were here in Washington during that time?

Dr. MEAD. That is right.

Senator DONNELL. Did you have occasion to study the experience of any foreign countries which have compulsory health insurance during the period of the war? Have you made studies?

Dr. MEAD. Not intimately, but I have knowledge of it.

Senator DONNELL. Would you state, please, what is your opinion derived from your study as to the success or lack of success of compulsory insurance as applied to dentistry in any of the foreign countries?

Dr. MEAD. I think it has been a failure.

Senator DONNELL. What countries particularly do you have in mind?

Dr. MEAD. It has been used in Germany, in Russia, and a great many of the countries have used some form or another.

Senator DONNELL. Great Britain likewise?

Dr. MEAD. That is right.

Senator DONNELL. And you say your observation—your opinion, I should perhaps more correctly say—from the study of the compulsory health insurance as applied to dentistry in foreign countries, is that it has been a failure; is that correct?

Dr. MEAD. As compared with our system; yes.

Senator DONNELL. As compared with the system we have; yes, sir.

Dr. MEAD. That is right.

Senator DONNELL. Now, Doctor, some resolution was made earlier, at the eighty-seventh meeting of the American Dental Association reading in part as follows:

> Opposed to the establishment of means test at the Federal level for a program of dental care holding that the desirability of such a test should be determined at the State level.

Is there any comment that you desire to make with respect to the history of this resolution or what happened to it?

Dr. MEAD. The house of delegates has the power to determine policy in the American Dental Association; it has repeatedly, through the years, made statements to the effect that they do not believe in free dentistry to those who can afford to pay. There was a resolution that went through that was ambiguous in its meaning that stated that if there was a bill in Congress that had a means test at the national level, we should oppose it, and if there was a bill and that bill should be for or against at national level—so I called an interim meeting of the board of trustees who had power at that time.

Senator DONNELL. After the house of delegates passed this ambiguous resolution.

Dr. MEAD. And we cleared the wording of that, and we came to the decision that there was no conflict in the philosophy as expressed in the Taft letter and bill which we had as to the dental health care in the house of delegates of the American Dental Association, because dentistry believes in giving free dentistry to only those who cannot afford to pay, but they want it determined not at national level.

In other words, they want the State to use a test of some kind, but they want the State to determine the method that they will use as to how they can do it—whether it shall be asking them, whether they want the principal of the school to do it, or how they determine it. That is left to the State.

Senator DONNELL. So the ad interim meeting to which you refer determined that the meaning of the resolution of the American Dental Association was to differentiate between the means test at the Federal level and the means test at the Sate level.

Dr. MEAD. That was the only question involved.

Senator DONNELL. That was the only question involved, and the American Dental Association, according to this resolution, at the interim meeting you referred to, did not intend to oppose the type of provision set forth in the Taft bill which would provide for a Statewide program for services to persons having insufficient income to pay the whole cost of same.

Dr. MEAD. The purpose of that meeting was to determine what was meant by that ambiguous statement. There was unanimity expressed that the policy was as I have expressed it to you.

Senator DONNELL. In other words, the philosophy of the American Dental Association as determined in interim meeting is entirely in harmony with the provision of the Taft bill to which I referred as far as the philosophy with regard to free dental service is concerned.

Dr. MEAD. Yes, sir.

Senator DONNELL. Doctor, I want to ask you on this matter of preventive dentistry: It was suggested by Senator Pepper that we have a great deficiency in number of dentists. Just leaving that aside for the moment, is it not a fact that this fluorine matter to which you referred is considered by leading dentists to be one which has great possibilities in the way of prevention of the necessity for dental work?

Dr. MEAD. That is correct.

Senator DONNELL. For instance, you know Dr. H. Trendley Dean. He is senior dental surgeon of United States Public Health in charge of infectious diseases, Bethesda, Md., is he not?

Dr. MEAD. Yes.

Senator DONNELL. Let me read just a short paragraph from an article by Dr. H. Trendley Dean which was printed in the Journal of the American Water Works Association, September 1943, volume 35, No. 9; and I ask you, Doctor, whether or not you concur with the views expressed. The title is "Domestic Water and Dental Caries."

> The chief hope of meeting the problem of meeting the needs of the entire population lies in drastically reducing the incidence of dental caries in the population. A decade ago the postulation that dental caries might be subject to mass control would have labeled its originator an unbridled visionary. Today, the unprecedented disclosures of the relationships of fluorine to dental caries indicates that it has a logical scientific foundation.

Do you concur with that observation, Dr. Mead?

Dr. MEAD. Yes; I do.

Senator DONNELL. Is it an overstatement that the number of holes in people's teeth may be cut in half by adding fluorine in small quantities to drinking water for the entire population of cities? Is that correct or not?

Dr. MEAD. There are many plans in existence at the present time and many of them feel that is a possible solution. Of course, it remains for further experiments to prove that.

But there is another angle also, Senator. There is now new knowledge that dentistry, through the plans in different communities, is able to cut down the number of cavities, the incidence of caries, by at least one-half and by an intelligent following of the rules set down by the American Dental Association Council on Dental Health for early inspection, frequent inspection, and the carrying out of early attention to these cavities.

It is the cost and the enormous extent of the problem as occasioned by the lack of dental education, by lack of the knowledge of the people to go early at the time when it can be least expensive and the least extensive.

Senator DONNELL. Now, Doctor, am I correct in the view that as the proper study of preventive measures shall increase, the necessity for more dentists would decrease?

Dr. MEAD. That is correct.

Senator DONNELL. And whereas today it might look on first blush that the number of dentists that were mentioned here this morning would not be sufficient here for the public and perhaps we do need some more—nevertheless it is easily possible in one's own mind to exaggerate the number of dentists that might be required in view of the fact that studies can be made to reduce the incidence of caries; that is correct; is it not?

Dr. MEAD. That is correct.

No one could forecast the future at the present time.

Senator DONNELL. And your own observation at the present time is that you are inclined to the view that there is by no means as great a deficiency in the number of dentists as some people might judge?

Dr. MEAD. That is correct, Senator.

Senator DONNELL. Would you mind just characterizing in your own language as to what you would say as to whether or not there is a shortage of dentists in the country or whether it is a question of distribution?

Dr. MEAD. More a question of distribution than other problems.

We have seen the time in the not too-distant past where many dentists did not have enough to do. But when there were many dentists, approximately 23,000 of our best men in the service, the public was deprived of their services. There is a backlog of dentistry to be done. We are in an era now where there is the greatest attention to shortage; as to whether that is going to be in the future depends on catching up with the problem and reducing the size of the problem. I believe the shortage of dentists is exaggerated.

Senator DONNELL. Now, Doctor, referring to S. 545—do you have a copy of it—will you please turn to page 9, Doctor, where you will observe as one of the components "the Office of Dental Care Services"? You notice that, do you, up at the top of the page, line 1, page 9?

Dr. MEAD. Yes, sir.

Senator DONNELL. Then if you will observe at lines 17 to 20 [reading]:

> The Director of the Office of Dental Care Services shall be a doctor of dental surgery who has had at least 10 years of active practice and who is outstanding in the field of dentistry.

You see that, do you not?

Dr. MEAD. Yes, sir.

Senator DONNELL. I understand—and if you differ from that, please so state—I understand that there is to be provided in this agency a number of constituent units of which the Office of Dental Care Services is one and the directors of that Office of Dental Care Services is required by this bill, S. 545, to be a doctor of dental surgery who has had at least 10 years of active practice and who is outstanding in the field of dentistry.

Dr. MEAD. Yes, sir.

Senator DONNELL. I call to your attention a provision of S. 1320. If you will be kind enough to turn to pages 38 and 39 of that bill, you will observe the creation of a National Health Insurance Board, three of whom shall be appointed by the President, by and with the advice and consent of the Senate, and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security. On lines 7 and 8 you note it says, "At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States."

I do not observe anything there that requires any one of those appointed men to be a dentist. Do you see anything in that bill that so requires?

Dr. MEAD. No; I do not.

Senator DONNELL. You note also, do you not, at the bottom of the page, line 22 and the following—"all functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator"?

Now the Federal Security Administrator you know as a matter of fact is Mr. Watson Miller who is not a doctor or dentist; you know that to be a fact, do you not?

Dr. MEAD. Yes.

Senator DONNELL. Now, Doctor, this National Health Insurance Board is to consist, in addition to the three who are required to be appointed by the President—not one of whom is required to be a dentist—it consists of two other persons, namely the Surgeon General of the Public Health Service and the Commissioner for Social Security.

Now you know that the branch of which the Surgeon General is the head, namely the Public Health Service, is a part of the Federal Security Administration, do you not?

Dr. MEAD. Yes.

Senator DONNELL. And you know also that the Commissioner for Social Security is likewise a part of the Social Security Agency of the Nation and you know that Mr. Altmeyer is the Commissioner for Social Security at the present time. Now, Doctor, I want to ask your opinion, bearing in mind the comparative component of that feature, namely that constituent units of the National Health Agency shall be the Office of Dental Care Services, with a mandatory provision that the director of that office shall be a doctor of dental surgery who has had at least 10 years active practice and who is outstanding in the field of dentistry—compare that with the provision of S. 1320 which puts two officials, namely the Surgeon General and the Commissioner for Social Security and the Federal Security Administration over all of them, all three of which individuals are under the Social Security Agency which does not provide that any one of the members of that National Health Insurance Board under S. 1320 shall be a dentist, bearing all these facts in mind, which one of these two bills, S. 545 or S. 1320 in your judgment best insures that proper attention would be given to the development of dental care and the development of the study of dental hygiene and service to the Nation?

Dr. MEAD. Administration of dental health care is far more favorable under the Taft bill, S. 545.

Senator DONNELL. That is all, Mr. Chairman.

Senator PEPPER. Doctor, I just wanted to ask you, have you by any chance seen S. 1131, a bill which I introduced earlier in this session, setting up a Federal-grant program making funds available to the States upon a matching principle with which to award, according to their own standards and selections, scholarships to deserving young men and women and making available loan funds payable back over a period of 20 years at 3 percent rate of interest per year in order to encourage boys and girls to get technical and adequate educational training? Have you seen that bill?

Dr. MEAD. I have seen the bill but I do not know the details. Dr. Flagstad would be more familiar than I am with that bill.

Senator PEPPER. I was going to ask as to the general principle of Federal funds being made available to States so they might with complete freedom work out their own plans for use of those funds; I say, do you favor the principle of the Federal Government providing such funds in conjunction with the States for awarding scholarships and making loans to deserving boys and girls to enable them to get an education and technical training?

Dr. MEAD. Yes; there the principle is one that I would need to know all the angles to know whether I agree; but there are certain boys who do not have money that want to take dentistry and I pointed out it would be possible. It is possible that they may go into these uneconomic areas; there is some possibility along that line.

Senator PEPPER. Such a principle might make available funds which would permit students to get dental education and become practicing dentists who otherwise would not be able to do so.

Dr. MEAD. That is possible.

Senator PEPPER. Thank you.

Mr. Chairman, I would like at the conclusion of Dr. Mead's testimony, since question has been raised here about the effects of the medical plans in effect in New Zealand, to have a letter, a statement by W. B. Sutch of New Zealand and appearing at page 2253 of part IV of the hearings on S. 1606; and also a statement of 1946 by Albert D. G. Blanc in a letter from New Zealand to Senator Murray appearing at page 3001, in part V of the hearings on S. 1606—they are only short letters and I would like to have them as part of the record.

Now, there is an exhibit 22, Interim Report of the Interdepartmental Committee on Dentistry presented by the Minister of Health and Secretary of the State for Scotland Parliament by Command of His Majesty, November 1944, appearing in the hearings on S. 190 and S. 1099, the two dental bills, the one being a dental research bill and the other a dental care bill, at hearings held last year. Since that last one is quite long, I just suggest that be incorporated by reference instead of having the expense of having it repeated; but I would like those other two carried in the record.

Senator SMITH. There is no objection and it is so ordered.

(The several documents referred to are filed with the committee.)

(The statement by Mr. Sutch is as follows:)

## STATEMENT BY W. B. SUTCH[1] OF NEW ZEALAND

During my present stay in the United States, I have been struck by the character of some of the unwarranted criticisms leveled against the New Zealand health-benefit program, viz:

1. That it is "socialized" medicine.
2. That it has resulted in a deterioration in the quality of medical care.
3. That it has led to unreasonable patient demands on the time of the doctor.

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[1] Director, procurement and shipping, southwest Pacific area, United Nations Relief and Rehabilitation Administration. Former economist to the Minister of Finance, New Zealand Government; member of the New Zealand delegation to the Imperial Conference, 1936, of the New Zealand delegation, League of Nations, 1937; author, The Quest for Security in New Zealand, 1942, Poverty and Progress in New Zealand, 1941.

4. That it has been abused by the doctor.
5. That it faces failure and bankruptcy.

New Zealand's health benefits include free treatment by a general practitioner at home or office, hospital care, treatment in the out-patient department of a hospital, maternity care, pharmaceutical prescriptions, X-ray diagnostic services, physical therapy, visiting nurse service, and part payment of specialists' fees. These services are free to all members of the public, but as in the field of education, individuals are at liberty to make their own arrangements and some do in fact.

When I say the benefits are free I do not imply thereby that someone is getting something for nothing. The money to pay for the benefits comes out of the social-security fund, which is financed largely by a special social-security tax on the income of every income receiver in the Dominion. The money thus raised goes in part to pay the fees to doctors, hospitals, nurses, pharmacists, and so forth, who elect to participate in the scheme. Practically all do.

Now as to the charges made against the New Zealand system.

First, that it is "socialized" medicine. If this charge is another way of saying that New Zealand has state medicine, then the critics had better take a closer look at us. State medicine is the provision of health services to the general public by salaried practitioners paid by and under the direction of the government. Most countries have some state medicine. Even the United States has it—your public general hospitals and clinics for the poor, your tuberculosis and mental-disease hospitals, for instance, or your free medical service to veterans through the Veterans' Administration and for merchant seamen through the marine hospitals of the United States Public Health Service.

The New Zealand health-benefit program is not state medicine because the overwhelming majority of doctors still make their living from patients' fees. This is your present system here. In New Zealand, with the exception of a handful of physicians in sparsely settled areas, who are on salary, and another small group who prefer to be paid so much per person per year under their care (capitation payments), the general practitioner derives his income from fees charged for services rendered. The only difference from the common practice in your country is that the fee is paid by the social-security fund, rather than by the patient, or is repaid by the fund if paid by the patient. The doctor is free to arrange with the patient that he pay an additional fee, and some in fact do; it is my impression, however, that the majority of doctors by and large abide by the general purpose of the health-benefit system and confine their charges to the liberal amount paid by the social-security fund. And let me add that I think that most of them prefer that to the old arrangement under which the doctor tends to assess the ability of the patient to pay fees, soaking the rich where he can, giving free service to the very poor, and being generally unhappy about the whole business because his training makes him a doctor and not a tax assessor or a real-estate appraiser.

Now the general purpose of the system—and this brings me to the heart of the matter—is simply this, to make sure that people in need of medical care can get it, irrespective of their economic circumstances. New Zealand decided in 1938, when we passed our Social Security Act, that the health of the people is as much a public concern as education or fire protection; and that like education and fire protection, health services should be available to all. Now there are several ways to get health services to the people. One way is the hit-or-miss, catch-as-catch-can method in effect in most countries and such as we had. That we found to be unsatisfactory. Another is state medicine—all doctors on the government pay roll. A third method and the one we chose was the creation of a fund, to which all would contribute on the basis of their ability to pay, and out of which we would pay the doctor, the hospital, the nurse, and the dispenser of drugs, for services and materials rendered as people need them. This is the system we have. All contribute, through a 5-percent social-security tax on income; all benefit, by applying for and getting health care as they need it. The arrangement is in effect merely a pooling of risks, since all of us, including the healthiest, have occasion to see a doctor or to use a hospital at some time or other and it makes no sense to deprive some of us of medical care simply because we do not have the money to buy it at the particular time we need it.

Today everybody in New Zealand has access to medical care. Though many medical and organizational problems remain to be solved that is the outstanding fact about our health-benefit program. In spite of wartime shortages of doctors and nurses, it has meant more health services to more people than at any time in our history. That is progress, and progress in the right direction, and although I for one would like to see more group practice and less individual practice, more emphasis upon the organization of district health centers and less upon the maintenance of the status quo, I cannot help but recognize that in its aim to remove considerations of cost from the receipt of medical care, the Government has been successful.

Now as to quality of care. Quality is hard to measure. I don't want to pass judgment on the quality of health services in New Zealand today. I am not a medical man. Speaking as a layman, however, I wish to point out that the whole case for the alleged deterioration in the quality of care rests upon the assumption that we have had a wholesale reorganization in the pattern of medical practice. That assumption has no basis in fact. Our doctors are the same doctors we had in 1940, before the establishment of the medical benefit. Patients still choose their own doctors. Doctors are still free to accept or reject patients. What they do with patients, short of malpractice, is still their own professional concern. Hospital boards still run their own institutions and drug dispensers their own establishments. The only difference from the old arrangement is the source of the money for payment. Why this should make any difference with respect to the quality of service rendered is a complete mystery to me and I am sure to any impartial observer.

It is true, that a few doctors have probably taken advantage of the security of income afforded by the fund to go in for overconsultation with patients. That is bad. No one defends it. The Government, I may say, is well aware of this fact and is discussing with the New Zealand branch of the British Medical Association what should be done about these few doctors whose actions may not be in accordance with professional ethics. Where, as in both New Zealand and this country, the number of patients to be seen and the frequency of visits is left strictly to the professional judgment and private conscience of the doctor, it is difficult to prove abuse. Responsibility for proper policing is not wholly the Government's, I may add. The profession, too, has a responsibility.

I want to say a word about the related subject of doctor income. One of the more frequently heard objections to any kind of rational reorganization of health services is the alleged effect upon the doctor's economic rewards. He will make less money, it is said, and because he will make less money, the argument goes on, his incentive to give the best that is in him will be seriously impaired. This comment is not, of course, particularly flattering to the doctor; but assuming it to be true, what are the facts? The fact is that never before in the history of the Dominion has doctor income been so high, never before have the economic rewards for the general practitioner been quite so attractive. The combination of opportunities to render medical service unhampered by patient ability to pay, plus a guaranteed payment per service, has served to put the medical profession in New Zealand nearer the top of the economic pyramid than in any other county. It is the opposite of what some of the critics of health benefits have feared. Doctors have not become poorer. If anything, the medical profession is getting too great a share of the national income.

The other kind of abuse to which it is said our system lends itself may now be mentioned—unreasonable patient demands on a doctor's time and effort. There is some of that, too; not as much however as observers 10,000 or more miles away think they see. Of course, there are a few neurotics in New Zealand, as there are in this country, too. They may pester the doctor for trivial or imaginary ailments. They are overanxious about a condition very well in hand from a professional point of view. If they think their present doctor is unsympathetic to their needs as they see them, they go to another. They shop around. This is no new problem. We had such people before. You have them now. The problem, however, is minor and is one of proper administration. Regulations have been issued, the effect of which is to spot the hypochrondriacs and support the doctor in his refusal to give more service than the situation warrants. Some of these neurotics, I may mention in passing, are really emotionally or mentally unwell, and need more rather than less medical attention.

You will have gathered from all I have said that the intervention of the Government in the relations of doctor and patient, hospital and patient, and pharmacist and patient, is restricted to the economic sphere. The Government pays the bill. It doesn't tell the doctor how to practice medicine or the pharmacist how to compound prescriptions. Of bureaucracy, therefore, if I may use that much-abused word, there is relatively little, and I mention it not because it is an issue in New Zealand, but because I understand it has become one in this country, however imaginary it may be in relation to our system.

Lastly, a word about the bankruptcy which the Journal of the American Medical Association says stares us in the face. We finance our social-security program, as I've said, out of the receipts of a 5-percent tax on income. This source is supplemented by a governmental contribution out of general revenues. This tax, since the beginning of the program, has provided about three-fourths of the receipts of the fund; a registration fee about 3 percent; and the Government contribution the balance. Most of the fund's expenditures are for cash benefits for the aged, widows, orphans, invalids, the sick and unemployed, and for our children's-allowance scheme. The health benefits last year represented about 30 percent of the fund's expenditures, and administration, including the cost of tax collections, about 3 percent.

Since the fiscal basis of the social-security program—cash benefits and health benefits together—rests upon taxes, and these are geared to yield enough to pay the benefits, the case for the charge of bankruptcy rests in the last analysis upon the ability of the national economy to pay these taxes. About that, there is not in my opinion any question. Unless we go into an economic tailspin which will curtail our whole standard of living, what we put aside out of current income will suffice to meet our obligations for cash benefits and health benefits. New Zealand's policy of full employment will insure this.

Only a few months ago, in order to meet expanded pension payments which are now in operation, Parliament strengthened the fiscal base by raising the social-security tax from 5 to 7½ percent, effective later this year. We were enabled to do this by reducing our national security or war tax from 7½ to 2½ percent, which means a net saving to taxpayers for both taxes combined of 2½ percent. We spent hundreds of millions of pounds for the war, much of it out of increased taxes; we think it will not be too difficult to find 5,000,000 pounds for health benefits. It is worth at least that much to us in the improved health and well-being of our people.

Our system of health benefits is still young in New Zealand. It has problems and it is experiencing the usual growing pains. It has had to meet special difficulties because of the war. But it stood up under the trying conditions of wartime; and we haven't the slightest doubt that it will gain strength and efficiency in the next few years. And, whenever the government in office—for the opposition party also subscribes to social security—the system is here to stay.

(The letter from Dr. Blanc is as follows:)

WANAKA, NEW ZEALAND, *July 1, 1946.*

HON. JAMES E. MURRAY,
*United States Senate, Washington, United States of America.*

DEAR SIR: I have been following through more or less verbatim reports of the hearing on S. 1606 as reported in the Journal of the American Medical Association, to which journal I have contributed for some years.

I am very interested in the question of medical care, particularly as I have almost completed a book on social medicine, based mainly upon our experience in this country.

Under ordinary circumstances I would not presume to criticize certain aspects of the evidence tendered to your committee were it not that, directly and by implication, my own country has been mentioned. At the time of writing I have followed up the hearings until April 16 as reported in the J. A. M. A. of May 11, which is the latest issue to hand.

I might here say that I am opposed to the viewpoint of organized medicine on the question of a complete universal health-insurance scheme. I have worked such a scheme in all its aspects up to and including the present time. Although it has certain bad features—which could be corrected easily—the good ones far outweigh the bad.

There is a tendency for organized medicine in United States of America to hold up New Zealand as the bad boy of the family. I do not care what organized medicine in America privately thinks of the New Zealand scheme but it becomes another matter when they take the public platform and create impressions which have no foundation in fact. To cover the many aspects concerning this country's scheme which has been subject to criticism by organized medicine in the United States of America would take too long to cover adequately and, furthermore, in the sittings to come there may be many further points touched upon. I notice, for example, that Dr. Sensenich claimed that the population of the United States of America have enjoyed a better standard of health than any other country in the world. I emphatically disagree.

In his evidence, Dr. Cobb stated that, in 1942, the infant mortality rate for the white population of the United States of America was 37.3. This would appear to be a very favorable year from previous statistics in my possession. In that year, however, in this country our infant death rate was 28.71 for the white population. In round figures this means that the United States of America white population had seven and one-half more baby deaths per thousand births than we had in this country. In other words, roughly 20,000 white babies died that year in the United States of America who would have lived if they had been fortunate enough to have been born in a replica of the New Zealand environment.

I realize that you probably have all sorts of rules about admissibility of evidence and, in any case, the hearings may be over before you receive this letter. If however, a rough draft of the many chapters on social medicine in New Zealand (probably about 80,000 words) would be of use to you, publicly or privately, I would be only too willing to mail it to you. As far as it is humanly possible, I have tried to be absolutely honest in the presentation of the facts, even to the extent of devoting more time to the abuses than they probably warrant. Notwithstanding this, I think the facts indicate the decision of our Government to introduce this measure in this country.

Yours faithfully,

Albert D. G. Blanc.

Senator Smith. Have you any further comment you want to make Doctor?

Dr. Mead. No, sir.

Senator Smith. We thank you very much for your testimony. Your prepared statement will be included at this point, including the tables.

(Dr. Mead's brief is as follows:)

### Statement of the American Dental Association Before the Committee on Labor and Public Welfare, United States Senate, on National Health Bill Submitted by Sterling V. Mead, D. D. S., President of the American Dental Association

My name is Dr. Sterling V. Mead. I am a practicing dentist located in Washington, D. C., and president of the American Dental Association.

The American Dental Association has advocated the extension of dental service to more people for a number of years. Several bills to accomplish this purpose have been introduced in previous Congresses at the suggestion of the American Dental Association. In the Seventy-ninth Congress, extensive hearings were held on two bills sponsored by the American Dental Association, one to provide dental research and the other to provide grants-in-aid to the States for dental health programs. Both bills were supported by many outstanding witnesses. The Senate Committee issued a favorable report on the research bill and we wish to offer this report for insertion in the official records of this hearing.

The extension of adequate dental service to all children is one of the great and important health problems of today. Adequate dental service should be available to all children and if the parents of the child do not have sufficient income to pay for such service, then the service should be provided by the community.

The problem of making adequate dental service available to all children varies greatly from State to State. Some of the factors involved in this problem are shown in the following tables:

Table 1.—*Estimated funds available per child for dental program under S. 545, by regions*

| | Combined State-Federal allocation | Child population 1940 | Per-child expenditure |
|---|---|---|---|
| United States total | $40,000,000 | 34,764,080 | $1.12 |
| New England | 2,248,000 | 2,079,978 | 1.08 |
| Middle East | 8,064,000 | 7,955,988 | 1.12 |
| Southeast | 11,248,000 | 8,813,643 | 1.28 |
| Southwest | 3,708,000 | 2,884,352 | 1.28 |
| Central | 10,084,000 | 8,878,319 | 1.14 |
| Northwest | 2,312,000 | 2,030,396 | 1.14 |
| Far West | 2,340,000 | 2,121,404 | 1.10 |

If average allocation is based upon children attending school, rather than total child population, then there would be approximately $1.50 per child as a national average.

Note.—While the regional data tend to level off wider differences between individual States, they still indicate that there is only a relatively small range between per capita funds which may be available to economically less favorable States as against economically favorable States. This results from the fact that total population is considered in establishing allocations; while relatively "poorer" States have a greater proportion of children in relation to the total population.

Table 2.—*Estimated number of children by age groups, in the United States, July 1, 1952*

| Age: | |
|---|---|
| Under 5 years | 11,729,000 |
| 5 to 9 years | 13,852,000 |
| 10 to 14 years | 12,319,000 |
| 15 to 19 years | 10,852,000 |
| Total, under 20 years | 48,752,000 |
| Total, age 5 to 18 years | 34,853,000 |

Table 3.—*Percentage of children attending school (all races) by age for the United States—1940 Census*

| Age: | *Percent* |
|---|---|
| 5 years | 18.0 |
| 6 years | 69.1 |
| 7 to 9 years | 94.3 |
| 10 to 13 years | 95.5 |
| 14 years | 92.5 |
| 15 years | 87.6 |
| 16 to 17 years | 68.7 |
| 18 to 19 years | 28.9 |

Table 4.—*Number and percentage distribution of total population, children aged 5 to 19, and active dentists, by regions: 1940 census*

| | Total population | Percent | Children, 5 to 19 | Percent | Dentists | Percent |
|---|---|---|---|---|---|---|
| Total, United States | 131,669,275 | 100.0 | 34,764,080 | 100.0 | 70,423 | 100.0 |
| New England | 8,437,290 | 6.4 | 2,079,978 | 6.0 | 5,038 | 7.1 |
| Middle East | 32,192,301 | 24.5 | 7,955,988 | 22.9 | 20,971 | 29.8 |
| Southeast | 28,261,829 | 21.5 | 8,813,643 | 25.4 | 7,371 | 10.5 |
| Southwest | 9,782,337 | 7.4 | 2,884,352 | 8.3 | 3,036 | 4.3 |
| Central | 35,741,574 | 27.1 | 8,878,319 | 25.5 | 22,321 | 31.7 |
| Northwest | 7,410,435 | 5.6 | 2,030,396 | 5.8 | 4,087 | 5.8 |
| Far West | 9,843,509 | 7.5 | 2,121,404 | 6.1 | 7,599 | 10.8 |

Table 5.—*Ratio of total population per dentist and chidren per dentist, by regions*

[Based upon 1940 census data]

| Region | Population—Dentist ratios | |
|---|---|---|
| | Total population | Children 5 to 19 |
| Total, United States | 1,870 | 494 |
| New England | 1,675 | 413 |
| Middle East | 1,535 | 379 |
| Southeast | 3,834 | 1,196 |
| Southwest | 3,222 | 950 |
| Central | 1,601 | 398 |
| Northwest | 1,813 | 497 |
| Far West | 1,295 | 279 |

Source: Prepared by Committee on Dental Economics, American Dental Association.

TABLE 6.—*Number and distribution of children aged 5 to 19, dentists, ratios of children per dentist, and total population per dentists, by region and State: 1940 census*

| Region and State | Children, 5 to 19 | | Dentists | | Children per dentist | Index of ratios (U. S.=100) |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | | |
| United States total | 34,764,080 | 100.0 | [1] 70,423 | 100.0 | 494 | 100 |
| New England | 2,079,978 | 6.0 | 5,038 | 7.1 | 412 | 83 |
| Connecticut | 408,926 | 1.2 | 1,085 | 1.5 | 377 | 76 |
| Maine | 230,092 | .7 | 378 | .5 | 609 | 123 |
| Massachusetts | 1,043,980 | 3.0 | 2,822 | 4.0 | 370 | 75 |
| New Hampshire | 122,441 | .4 | 224 | .3 | 547 | 111 |
| Rhode Island | 179,364 | .5 | 377 | .5 | 476 | 96 |
| Vermont | 95,175 | .3 | 152 | .2 | 626 | 127 |
| Middle East | 7,955,988 | 22.9 | 20,971 | 29.8 | 379 | 77 |
| Delaware | 64,331 | .2 | 105 | .2 | 613 | 124 |
| District of Columbia | 127,014 | .4 | 496 | .7 | 256 | 52 |
| Maryland | 464,959 | 1.3 | 873 | 1.2 | 533 | 108 |
| New Jersey | 993,610 | 2.9 | 2,690 | 3.8 | 369 | 75 |
| New York | 3,065,848 | 8.8 | 10,260 | 14.6 | 299 | 61 |
| Pennsylvania | 2,636,611 | 7.6 | 5,950 | 8.5 | 443 | 90 |
| West Virginia | 603,615 | 1.7 | 597 | .9 | 1,011 | 205 |
| Southeast | 8,813,643 | 25.4 | 7,371 | 10.5 | 1,196 | 242 |
| Alabama | 919,130 | 2.6 | 605 | .9 | 1,519 | 307 |
| Arkansas | 611,526 | 1.8 | 384 | .6 | 1,593 | 322 |
| Florida | 493,831 | 1.4 | 717 | 1.0 | 689 | 139 |
| Georgia | 972,475 | 2.8 | 825 | 1.2 | 1,179 | 239 |
| Kentucky | 873,664 | 2.5 | 796 | 1.1 | 1,098 | 222 |
| Louisiana | 712,210 | 2.0 | 788 | 1.1 | 904 | 183 |
| Mississippi | 706,878 | 2.0 | 419 | .6 | 1,687 | 342 |
| North Carolina | 1,190,071 | 3.4 | 788 | 1.1 | 1,510 | 306 |
| South Carolina | 654,115 | 1.9 | 361 | .5 | 1,812 | 367 |
| Tennessee | 874,935 | 2.5 | 844 | 1.2 | 1,037 | 210 |
| Virginia | 804,808 | 2.3 | 844 | 1.2 | 954 | 193 |
| Southwest | 2,884,352 | 8.3 | 3,036 | 4.3 | 950 | 192 |
| Arizona | 148,871 | .4 | 154 | .2 | 967 | 196 |
| New Mexico | 173,892 | .5 | 114 | .2 | 1,525 | 309 |
| Oklahoma | 704,621 | 2.0 | 744 | 1.0 | 947 | 192 |
| Texas | 1,856,968 | 5.3 | 2,024 | 2.9 | 917 | 186 |
| Central | 8,878,319 | 25.5 | 22,321 | 31.7 | 398 | 81 |
| Illinois | 1,834,035 | 5.3 | 5,970 | 8.5 | 307 | 62 |
| Indiana | 865,925 | 2.5 | 1,814 | 2.6 | 477 | 97 |
| Iowa | 648,719 | 1.9 | 1,623 | 2.3 | 400 | 81 |
| Michigan | 1,360,992 | 3.9 | 2,657 | 3.8 | 512 | 104 |
| Minnesota | 716,443 | 2.1 | 2,078 | 2.9 | 345 | 70 |
| Missouri | 941,332 | 2.7 | 2,293 | 3.2 | 411 | 83 |
| Ohio | 1,697,616 | 4.9 | 3,772 | 5.4 | 450 | 91 |
| Wisconsin | 813,257 | 2.3 | 2,110 | 3.0 | 385 | 78 |
| Northwest | 2,030,396 | 5.8 | 4,087 | 5.8 | 497 | 61 |
| Colorado | 293,467 | .8 | 666 | .9 | 441 | 89 |
| Idaho | 149,867 | .4 | 215 | .3 | 697 | 141 |
| Kansas | 469,945 | 1.4 | 1,014 | 1.4 | 463 | 94 |
| Montana | 144,450 | .4 | 277 | .4 | 521 | 105 |
| Nebraska | 352,086 | 1.0 | 920 | 1.3 | 383 | 78 |
| North Dakota | 194,846 | .6 | 262 | .4 | 744 | 151 |
| South Dakota | 185,282 | .5 | 303 | .4 | 611 | 124 |
| Utah | 172,413 | .5 | 306 | .4 | 563 | 114 |
| Wyoming | 68,040 | .2 | 124 | .2 | 549 | 111 |
| Far West | 2,121,404 | 6.1 | 7,599 | 10.8 | 279 | 56 |
| California | 1,458,408 | 4.2 | 5,447 | 7.7 | 268 | 54 |
| Nevada | 24,113 | .1 | 55 | .1 | 438 | 89 |
| Oregon | 247,554 | .7 | 835 | 1.2 | 296 | 60 |
| Washington | 391,329 | 1.1 | 1,262 | 1.8 | 311 | 63 |

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[1] Dentists in active practice or seeking work as reported for separate States. Another Census report gives a total figure of 70,601.

Sources: Sixteenth Census of the United States, Bureau of the Census, vol. II, Characteristics of the Population; vol. III, The Labor Force.

TABLE 7.—*Estimated funds available per child for dental program under S. 545, by States*[1]

| State | Combined State-Federal allocation | Per child | State | Combined State-Federal allocation | Per child |
|---|---|---|---|---|---|
| Total | $40,000,000 | $1.12 | Montana | $130,200 | $0.90 |
| | | | Nebraska | 381,200 | 1.08 |
| Alabama | 1,087,520 | 1.18 | Nevada | 36,120 | 1.50 |
| Arizona | 221,920 | 1.49 | New Hampshire | 159,200 | 1.30 |
| Arkansas | 688,240 | 1.13 | New Jersey | 977,120 | .98 |
| California | 1,194,840 | 1.30 | New Mexico | 206,960 | 1.19 |
| Colorado | 347,040 | 1.18 | New York | 2,692,640 | .88 |
| Connecticut | 371,520 | .91 | North Carolina | 1,355,240 | 1.14 |
| Delaware | 64,760 | 1.01 | North Dakota | 166,640 | .86 |
| District of Columbia | 214,920 | 1.69 | Ohio | 1,734,080 | 1.02 |
| Florida | 835,840 | 1.69 | Oklahoma | 786,720 | 1.12 |
| Georgia | 1,234,280 | 1.27 | Oregon | 301,920 | 1.22 |
| Idaho | 160,160 | 1.07 | Pennsylvania | 2,551,480 | .97 |
| Illinois | 1,895,560 | 1.03 | Rhode Island | 186,000 | 1.04 |
| Indiana | 975,080 | 1.13 | South Carolina | 736,880 | 1.13 |
| Iowa | 702,840 | 1.08 | South Dakota | 191,000 | 1.03 |
| Kansas | 534,880 | 1.14 | Tennessee | 1,113,240 | 1.27 |
| Kentucky | 997,000 | 1.14 | Texas | 2,504,680 | 1.35 |
| Louisiana | 949,760 | 1.33 | Utah | 191,280 | 1.11 |
| Maine | 243,120 | 1.06 | Vermont | 104,080 | 1.09 |
| Maryland | 539,080 | 1.16 | Virginia | 1,110,520 | 1.38 |
| Massachusetts | 1,033,280 | .99 | Washington | 468,480 | 1.20 |
| Michigan | 1,395,400 | 1.03 | West Virginia | 666,920 | 1.10 |
| Minnesota | 823,960 | 1.15 | Wisconsin | 882,440 | 1.09 |
| Mississippi | 801,480 | 1.14 | Wyoming | 75,360 | 1.11 |
| Missouri | 1,154,560 | 1.23 | Territories and possessions | 1,119,560 | -------- |

[1] Based upon allocations presented in Committee on Labor and Public Welafre document dated Feb. 12, 1947, as published in the Journal of the American Dental Association, Apr. 1, 1947, p. 510. Per-child allocation computed upon total child population aged 5 to 19 in each State, as reported in the 1940 census. There will probably be about 1,000,000 more children in this age group in 1952 than there were in 1940, which will cause a slight decrease in the amount available per child in most States.

Source: Committee on Dental Economics, American Dental Association.

*Table 1.*—Assuming that all States will elect to participate in the program, then in 1952 there will be a total Federal and State expenditure of $40,000,000, which will make available an average of about $1.15 per child according to the estimated poplation in 1952 for the age groups 5 to 18. A regional comparison based upon the 1940 census and an estimated allocation to the States in accordance with the provisions of S. 545 indicates there will be relatively little difference in the amound available per child.

*Table 2.*—assuming that all States will agree to participate, and will arrange to extend the program upon the basis of the schedule outlined in the bill, then by 1952 all school children in the United States will be eligible for a "periodic inspection." The Bureau of the Census forecaste recently (population—Special Report, Series P–46, No. 7, September 15, 1946), that the total population of the United States in midyear 1952 will be approximately 147.5 million. Of this number about one-third, or 48,000,000 will be under the age of 20. From this number should be subtracted the number of children of preschool age (generally under 5) and the number over high-school age (generally taken as over age of 18). The number of children aged 5 to 18 in the United States will thus be approximately 35.0 million, distributed as shown in table 2.

*Table 3.*—A more detailed break-down of the percentage of children standing school by age for the United States, 1940 census, is given in table 3.

*Table 4.*—The regional summary given in table 4 presents the percentage distribution of the total population, children aged 5 to 19, and active dentists. It provides a general picture of the relative difficulty each region will have in carrying out a children's dental program. The New England region is found to have 6.4 percent of the total population, 6.0 percent of the child population, and 7.2 percent of the total active dentists—a relatively equal distribution. The Southeast, on the other hand, had in 1940, 21.5 percent of the total population, 25.4 percent of the children (the children being a greater proportion of the population than in other regions), and 10.5 percent of the dentists. The far West had 7.5 percent of the total population, 6.1 percent of the children, and 10.8 percent of the dentists—by far the most favorably situated region to carry out a children's program.

*Table 5.*—Table 5 presents the ratio of total population per dentist and children per dentist, by regions, together with an index for more directly comparing the differences within each region and between regions.

### DENTAL INSPECTION

No definition of the contents of an inspection or the frequency of inspection is given in the bill. We may assume that established standards concerning the completeness and frequency of dental examinations will be followed. At a minimum, dental scientists suggest one complete examination annually. Thus, this dental program, if established in all States, will require the examination of the mouths of 28,000,000 school children annually.

A recent report reveals that dentists in private practice required 9 mintes to perform an explorer examination with a chair assistant and required 11 minutes for the same operation when working alone. Since approximately half of the dentists reported using chair assistants, the average time for all dentists (those with and those without assitants) to perform an explorer examination was 10 minutes. An X-ray examination required 13 minutes with the aid of an assistant and 16 minutes working alone.

Twenty-eight million children receiving similar explorer examinations averaging 10 minutes, thus would require over 4.5 million hours of dentist time. It would take over 2,300 dentists working a full year, 40 hours a week for 50 weeks, with no lost time, to perform that number of examinations. Each dentist would perform an average of 12,000 examinations. This might be possible theoretically, but practical consideration would require the spreading of such work over many more dentists.

Further, dental hygienists and other auxiliary help would be of great value in developing a Nation-wide periodic dental inspection program for school children.

### SUMMARY

The factors involved in the problem of providing adequate dental health to children varies so greatly from State to State that each State should be permitted to establish a program that is fitted to the ability of the State to provide the necessary dental personnel and facilities for carrying out the program.

The dental program in each State can be increased as fast as additional personnel and facilities are obained so that each State may develop a program that will make dental health available to all school children.

Every dental inspection and treatment program should have an educational program associated with it to motivate people to take care of their dental needs and to preserve their dental health by preventive methods.

Dental health programs are necessary in all communities in the United States to aid in meeting the dental health problem of the public.

A reasonable amount of Federal grants-in-aid is necessary to encourage States to develop dental health programs to make available dental health education, dental inspection for children, and dental care for those with insufficient income to pay for such services.

There is an imperative need to increase dental research facilities as provided in S. 545 and in S. 176 in order to secure additional information which will aid in solving the problem of preventing dental disease.

Every individual in the Nation will benefit from such research. Therefore, the American Dental Association believes that the Federal Government should provide funds for this purpose.

Senator SMITH. The committee will stand recessed until next Wednesday morning at 9:30 a. m.

(Whereupon, at 12:10 p. m. the committee adjourned until 9:30 a. m., Wednesday, June 4, 1947.)

# NATIONAL HEALTH PROGRAM

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WEDNESDAY, JUNE 4, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met, pursuant to adjournment, at 9:40 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present Senators Smith and Murray.

Senator Smith. The committee will please come to order. I might say at the beginning that the reason I postponed starting a few minutes ago was because I had hoped Senator Lodge and Senator Saltonstall of Massachusetts might be here when we had this Massachusetts testimony. Unfortunately, however, like many other Senators, they are both engaged in other committee meetings, and I wasn't advised until just now that they couldn't be here, but they expressed their regrets at not being present when Dr. Bagnall and Dr. Hayden testify.

The first witness this morning is Dr. E. S. Bagnall of Groveland, Mass., who will testify before us on S. 545. Before starting your testimony, Doctor, I will ask you to give a little outline, if you will, of your background, a sort of biography, to qualify you as a witness in this matter.

## STATEMENT OF DR. E. S. BAGNALL, CHAIRMAN, COMMITTEE ON NATIONAL LEGISLATION, MASSACHUSETTS STATE MEDICAL SOCIETY, GROVELAND, MASS.

Dr. Bagnall. Mr. Chairman, I am a general practitioner. I am a past president of the State medical society. I was for about 8 years the secretary of the public relations committee. I am principally a general practitioner. I would like to emphasize that. I am school physician and agent of the board of health and medical examiner. I have been through the snowshoe and horseback days. I say that simply to emphasize the fact that I know the point of view of the general practitioner.

Senator Smith. Are you a "horse and buggy" doctor? [Laughter.] My father was; so I have great respect for the "horse and buggy" doctor.

Dr. Bagnall. When it became necessary on account of lack of transportation, I went through that stage. However, I am not far from a large city and I am a member of the senior staff of the hospital there. So that is briefly my background and I think I know the attitude of the people on this and the needs of the people.

Senator SMITH. Do you come here, Doctor, representing your own point of view or the point of view of the Massachusetts State Medical Society?

Dr. BAGNALL. That is right. I am chairman of the subcommittee on national legislation of the Massachusetts State Medical Society.

Senator SMITH. That covers the whole State of Massachusetts, doesn't it?

Dr. BAGNALL. That is right.

Senator SMITH. All right, Doctor, if you will go ahead with your story.

Dr. BAGNALL. The Massachusetts Medical Society favors ultimately the creation of a Federal Department of Health with a physician as Secretary in the Cabinet.

Senator SMITH. Let me interrupt there, if I may. You favor a separate Department of Health as distinguished from an over-all Department of Public Welfare, including social security, health, and other things. You feel it is important to have a separate Department of Health, do you?

Dr. BAGNALL. I do. That is ultimately, and I think, as I shall state later on, that these things should evolve gradually. I think my information is that it isn't practical to have a Cabinet officer now and, as I shall say later, the Taft bill, S. 545, is a good medium through which to evolve to the Cabinet position later.

Senator SMITH. All right, Doctor, go ahead.

Dr. BAGNALL. If this cannot be accomplished at the present time, the society believes that an independent health agency would constitute a marked improvement over the present arrangement in which some 30 constituent units in some 13 Federal departments and agencies are engaged in various phases of health work. It is, therefore, recommended that section 2, subsection (d), page 2, of S. 545, be amended by striking out the word "further" in line 17, and by placing a semicolon and the word "and" after the word "funds" in line 20; and that section 2, page 2, be amended by adding a new subsection "(e)" which shall state "that health and medical functions, being of a highly technical nature, do not lend themselves to administration by or under a nonmedical agency."

While the Massachusetts Medical Society recognizes the need for Federal grants in aid to States to subsidize public-health programs for all the people and medical-care programs for the medically and totally indigent, it believes that careful definition of what these programs are to encompass, both in the way of benefits and persons, is necessary.

In February 1946 the Massachusetts Medical Society adopted a set of basic principles which should govern medical-care plans. That is a fairly large committee and I think it is a good committee. Dr. Gadding, the health commissioner of Massachusetts, was on it and Dr. Allan Butler was on it, and after about 100 hours of discussion of principles and pending legislation at that time we unanimously agreed on the principles.

Senator SMITH. Do you have in your society a method of representation of all the doctors in the State?

Dr. BAGNALL. Yes; we do. The society is set up on the basis of representation of 1 councilor for each 20 physicians. They represent the council. Then the State society has standing committees and subcommittees. There is also a public-relations committee—one from each of the county societies. There is an executive committee—one from each of the county societies. So that there is thoroughly distributed throughout the organization a form of democracy.

Senator SMITH. You cover all the counties in the State of Massachusetts?

Dr. BAGNALL. That is right.

Senator SMITH. I notice here you refer to a set of basic principles which should govern the medical-care plans. That suggestion interests me a good deal. I am wondering whether those principles are all going to appear in your statement here or whether they are separately published.

Dr. BAGNALL. I am beginning on those now.

Senator SMITH. All right; thank you.

Dr. BAGNALL. In the light of these principles, S. 545 has certain strengths and certain weaknesses.

I. The objective of adequate medical care in our free society is to make available to everyone—regardless of race, color, creed, financial status, or place of residence—every known essential preventive, diagnostic, and curative medical service of high quality. The attainment of such medical care must necessarily be an evolutionary process that will require the cooperation of all concerned over a period of years.

S. 545 states that it is the policy of the Federal Government to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status. Actually, however, the bill is designed to assist the States to provide general health, hospital, and medical services for families and individuals with low incomes. It is suggested, therefore, that section 2, subsection (c), page 2, be amended by striking out lines 15 and 16, and substituting the words "services to every individual who is unable to obtain such services because of his low income;". It is also suggested that the phrase, "general health, hospital, and medical services." be clarified.

Senator MURRAY. May I ask a question there for clarification, Mr. Chairman?

Senator SMITH. Senator Murray.

Senator MURRAY. Doctor, I take it from this last statement of yours that the Taft bill in its present form will not accomplish the stated purpose in the bill and that the preamble should probably refer to low income groups, instead of using the words, "every individual, regardless of economic status."

Dr. BAGNALL. No. I think that can be clarified. I think the purpose of the bill is clear enough. I think in some parts of the bill it is clear enough that people who are in part able to pay or wholly unable to pay are all taken care of.

Senator MURRAY. Do you think this language, where it says S. 545 states that it is the policy of the Federal Government to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status—do you think that that is what the bill would accomplish?

Dr. BAGNALL. I think so.

Senator MURRAY. Do you think that if this bill is passed in its present form, then hereafter, every individual, regardless of race or economic status, will be able to get medical care?

Dr. BAGNALL. We have stated also that the attainment of this objective was to be followed along the paths of evolution. I have read that in the statement.

Senator MURRAY. You mean that eventually, the evolution taking place over years to come, such a result could be obtained?

Dr. BAGNALL. That is right.

Senator MURRAY. Of course, that is speculation to a large degree. We don't know what is going to be the situation in the world right now. We don't know what is going to happen to this country with the present state of things in the world and the threat of a serious depression in this country. We don't know whether we will be able to build and maintain democracy throughout the world or not. So that this is all speculation as to what is going to happen in the future.

Dr. BAGNALL. That is right. That is why we emphasize the necessity of its being gradual in the attainment of these objectives—one step at a time, as we can assimilate the progress that has already been made.

Senator MURRAY. Do you think, then, it is a good thing that someone in this country introduced this subject of proper medical care for the American people——

Dr. BAGNALL. I do.

Senator MURRAY. Because you realize, I am sure, as other very able doctors do over the country, that over the years nothing was being done with reference to providing adequate medical care to the American people.

Dr. BAGNALL. I don't think I quite agree with that, that nothing has been done.

Senator MURRAY. Well, something has been done by individuals here and there, but nothing effective has been done to accomplish the rendering of proper medical care to the American people, and the agitation as a result of this has stimulated thought and activities that are greatly beneficial to the American people. So you don't believe, then, in the attitude of some people who charge us with being Communists, fellow travelers, or Socialists because we have brought this to the attention of the American people?

Dr. BAGNALL. No, sir.

Senator MURRAY. You don't approve of that at all?

Dr. BAGNALL. No, sir.

Senator MURRAY. I am glad to hear you say that, Doctor, because I believe that is the attitude of every able and intelligent physician in the country that I have talked to, but, nevertheless, we have propaganda being put out even from the Capitol charging us with being collaborationists, fellow travelers, and so forth, which, of course, we feel very badly about. We don't think that we are entitled to that kind of treatment and that kind of propaganda, and I am very pleased that you don't approve.

Dr. BAGNALL. I think the rate of progression is the principal point of discussion. There are some people who want to see a revolutionary change very quickly. I don't agree with that.

Senator MURRAY. I don't agree with it either. I think we have been working on this thing now for 5 or 6 years here in the Congress.

Prior to that, nothing was being done, hardly anything was being done, except in individual cases around the country. But if something had been started on this about 20 years ago, we might have made some headway and there wouldn't have been any need for this agitation today. There was no organized movement to bring it about, and when the selective-service program was put into operation in this country, we began to find that there was a very serious situation in the country with reference to the lack of adequate medical care.

Dr. BAGNALL. I think that that was exaggerated and utilized for the purposes of both sides.

Senator MURRAY. Do you believe that the Selective Service made an exaggerated report of the facts?

Dr. BAGNALL. I think the figures were used for the advantage of those——

Senator MURRAY. But you don't repudiate the report itself, do you?

Dr. BAGNALL. No. I repudiate the interpretations.

Senator MURRAY. You mean the interpretations that some people made of them.

Dr. BAGNALL. That is right, and I think you will agree that both sides have utilized all the material that was available and utilized it not entirely in the public interest and sometimes they would go beneath the real truths of the situation.

Senator MURRAY. That is the customary practice in the United States, for each side to take the extreme view, and then a middle-of-the-road course comes along. We have had middle-of-the-course doctors come here and tell us that they realize that these conditions are bad and that they need, for instance, in the rural areas, some sort of a plan to stimulate doctors settling in those sections of the country and getting hospitals and clinics in various parts of the country which would greatly overcome the conditions that were shown up in that report.

Dr. BAGNALL. Yes.

Senator MURRAY. Thank you, doctor.

Senator SMITH. Doctor, I would like to make one suggestion in connection with these comments here. On page 2, where the policy is laid down, it says that it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services, and so forth. It doesn't say it is the policy of the Government to provide all those services; it is to make available, and the question that I think before us in S. 545 is, taking the over-all picture in S. 545, considering what exists in the States today, considering the availability to all people. Some people pay for it. If they can pay for it, we feel they should pay for it, but the purpose is to make it available to everybody, and I am just asking you to make it clear in the record whether you feel from your over-all study of this bill that that statement of policy is carried out in the plans as set forth in this bill.

Dr. BAGNALL. It seems to me that it is.

Senator SMITH. Well, if you will continue, Doctor.

Dr. BAGNALL. II. The success of any plan for medical care is dependent on the mutual cooperation of the public, those rendering professional services, and the administrative agencies. This cooperation can be obtained only if those rendering the services are convinced that they will have a continuing authoritative voice in the formulation and execution of policies and plans, thereby assuming their proper share of responsibility.

Senator SMITH. I suppose what you mean by that is that they don't want the formulation of policy taken out of their hands. You feel in the States where they have the responsibility for carrying out these things, that the local State groups should develop their policies to carry out the over-all purpose of this act and not have the policy dictated for them.

Dr. BAGNALL. Yes, and insofar as the execution of the program is concerned and insofar as their own part in that plan is concerned, it must be recognized that they have technical knowledge and that they should be properly and authoritatively represented on the policy-making level. There is a provision here for that which I will discuss a little later.

Senator SMITH. You will probably agree that the conditions in our States vary sufficiently, so that the local level policy making is a desirable feature to keep alive all the way through a health program in the United States.

Dr. BAGNALL. Yes. On the national level, S. 545 is to be administered by an independent agency headed by a licensed physician appointed by the President by and with the advice of the Senate. Provision is made for a consultative National Health Council of eight members appointed by the Administrator. Four of the members must be doctors of medicine. In the event that a State plan or modification thereof is not approved by the Director of the Office of Medical and Hospital Care Services, the State may request a hearing before the Council which may affirm or overrule the decision of the Director. This is the only real power that the Council has.

On the State level, S. 545 is to be administered by the State health agency which may, however, utilize the services of voluntary, nonprofit organizations. There is to be an advisory council appointed by the Governor which must include representatives of the State medical association, State hospital association, voluntary nonprofit medical and hospital care plans, and other groups interested in the improvement of medical and hospital services and in the better distribution thereof.

Should the Director of the Office of Medical and Hospital Care Services at any time determine that a State agency is not complying substantially with the provisions of a plan previously approved, that Federal funds have been diverted from the purposes for which they were allotted, or that the State and its governmental subdivisions have failed to provide at least as much money as they have received from the Federal Government, he must withhold further certification. In such instance, the State may appeal to the Federal courts.

While it is the obvious intent of S. 545 to solicit enlightened lay and professional guidance on both the Federal and State level, there is nothing in the bill guaranteeing such an arrangement. It is therefore recommended that section 104, subsection (d), page 10, be amended by adding the following sentence after the word "council" in line 16:

> The head of the Office of Maternal and Child Health shall take cognizance of and be guided by the advice of the Advisory Council.

That section 106, page 11, be amended by adding the following after the period in line 13:

> Such report shall include a record of consultations with all advisory councils, recommendations of all advisory councils and comments thereon.

That section 702, section (a), paragraph (2), page 15, be amended by adding the following after the word "purposes" in line 5:

> and the State agency shall take cognizance of and be guided by the advice of the State advisory council.

and that section 712, subsection (a), paragraph (2), page 17, be amended by deleting the semicolon in line 22 and substituting a period to be followed by the sentence:

> The State agency shall take cognizance of and be guided by the advice of the Advisory Council.

Now I realize the difficulties of giving the advisory agency power which was taken away from the administrator. It is necessary that the administrator have the power and responsibility, but it seems to me that in some instances it might be possible for an administrator to ignore his advisory board sufficiently so that it would not work in the public interest, and if there were a provision made for the publication of the points of view of the advisory council so that the public and Congress would know at least once a year where the differences lie, they might judge who was right on the issues, if the administrator chose to ignore the advice of his advisory council. That doesn't take away any of his power, but it does give an opportunity for the cards to be laid on the table at a later date.

Senator SMITH. You wouldn't make the advice of the advisory council mandatory. You would simply publicize the differences so that the people following it might know what the differences were.

Dr. BAGNALL. That is right. My opinion, which isn't worth anything in this connection, is that it is not practical to make an advisory council able to overrule its administrator in this case. I don't know, but that is the way it seems to me.

Now, provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State government. Part of the burden of this responsibility may be assumed by charitable agencies. We in Massachusetts would like to continue that so far as we can and so long as we can. Federal grants-in-aid to State programs administrated by State boards of health are an acceptable method of helping to meet this responsibility.

Senator SMITH. I don't want to get off the track there, but you have given me a thought. Do you feel if we provide Federal aid in the field of health that it would dry up the sources of contributions to health agencies?

Dr. BAGNALL. I am sure it will. It will dry up the sources of giving to charitable agencies for those purposes. Some of the voluntary agencies are not very efficient, either. I suppose there is a good deal of money wasted in voluntary charities.

Senator SMITH. That is true. You think we have got to the place where we need to do it in a more organized way and with help on the Federal and State level, both.

Dr. BAGNALL. I am sure we must.

Senator MURRAY. Do you think that gifts for purposes of this kind are getting thinner and scarcer all the time?

Dr. BAGNALL. Yes, sir.

Senator SMITH. Go ahead, Doctor.

Dr. BAGNALL. S. 545 provides that on or before 1949 the State administrative agency shall be the State health agency. In Massachusetts the relationship between the State health department and the medical society is eminently satisfactory. It is conceivable, however, that in certain States the medical profession might not have an authoritative voice in the formulation of policies and plans of the State health department and that under such circumstances the term "low-income" might be so interpreted as to make essentially the entire population eligible for benefits. It is therefore recommended that the term "low-income" be clarified as to its meaning and intent.

Senator SMITH. Is it your thought there, Doctor, that we might after study fix a certain figure as the base below which you consider the individual in the low-income class?

Dr. BAGNALL. I am sure it isn't practicable.

Senator SMITH. It wouldn't be practicable to fix it as an over-all thing for the entire country.

Dr. BAGNALL. I have read one time that half the southern counties had an annual money income per individual of $368, the figure which comes to mind; it is about that, and if you attempted to compare that with the figure that might exist in New York City, you can realize that horizontal levels are not going to be practical in the country at all. They might be practical in the States, but in the city of Boston, for instance, it might be decidedly different than in the town I live in, in the western part of the State, in the mountains. So that horizontal levels are certainly not the answer. The needs that are locally determined, it seems to me, is the best way.

Senator SMITH. I think you are right on that, that you have to determine locally the low-income group in an area, but I am not quite clear how you can define in this Federal bill a formula on which that can be determined.

Dr. BAGNALL. That is a difficult job. I am sure I am not able to answer that. We know what we mean when we say medically indigent and we know what we mean when we say indigent, but when it comes to defining that term for the benefit of all the people in the country, it is over my head.

Senator MURRAY. Doctor, for a long time there has been a tendency in the country to expect the medical profession to take care of these people who can't afford to pay. Don't you think that that is an unreasonable burden to place on the medical profession?

Dr. BAGNALL. I think it is. I would like to qualify that a little bit by saying that I am glad in instances that come to my attention to give the care, but I think essentially it is an unreasonable expectation.

Senator MURRAY. I think the medical profession all over the country is entitled to great credit for that, but I have been in some sections of the country where the people have come to me and told me that the doctors of the community had left. There was one doctor remaining in one community and I had a conference with him. He told me that he had a family to support and that he couldn't remain there any longer and that he was leaving the whole community without any medical care whatever. I had to wire the Red Cross in Washington. There was a good deal of sickness at the time; it was during the drought, and they had to give emergency assistance to that community. So there is an example where you can't put that burden on the medical profession.

Dr. BAGNALL. That is right. I think the Taft bill provides for the subsidy of the doctor in instances of that sort.

Senator MURRAY. We did it out there with the WPA. For instance, every doctor in my community was on the WPA.

Dr. BAGNALL. That is right. Massachusetts was one of the few States that didn't do that. I think there were four States that didn't do that.

Senator MURRAY. In general, the doctors were treating the poor people who had no means to pay and were collecting it from the WPA.

Dr. BAGNALL. That was under the Emergency Relief Administration.

Senator MURRAY. Yes.

Senator SMITH. You have left us with a difficult problem there of trying to define low income. You take any community. Probably they could figure out that part of the population which we call medically indigent. I talked to some of the doctors in the New York Academy of Medicine. They didn't arrive at a fine formula, but they think that can be ascertained, and, of course, that is the purpose of the so-called Taft bill, to reach that group and help them with this legislation.

I notice here you say where people can pay. Well, that probably is one of the main differences between this bill and Senator Murray's bill, where he feels the only way to solve this is by compulsory plans for everybody. That is the main issue we are discussing in these hearings. Whether your principle here is sound, where a person can pay that person should be expected to pay, the responsibility of the Federal and State Governments is simply to take care of the medically indigent, and also to see to it that an over-all plan would make the medical services available to everybody.

Dr. BAGNALL. I would like to say, Senator Murray, that if I did favor compulsory health insurance, my mind is open on the thing. I don't favor it now, but I do agree that it might ultimately prove necessary. If I felt I were convinced now that it was ultimately necessary, I still would proceed in the evolutionary way through the Taft bill. I wouldn't go to the over-all plan now because Government isn't ready, the doctors are not ready and the people are not ready, and it would seem to me there would be a good deal of chaos if the long jump were taken now.

Senator MURRAY. That is a very reasonable statement, it seems to me. Of course, as you say, you can't tell what the future holds for us and it may become necessary at some time in the future, but it does seem to me that we have gone a long time in this country without getting adequate care to a great number of our people, and we are studying it now. I myself would much prefer a voluntary system. I think every reasonable person would want a voluntary system if it could be made effective and do the job for the people of this country. That is the subject we are now studying and discussing, and we hope to find some answer to it.

Dr. Bagnall. I recognize that in the means test, which is involved in the Taft bill, there is a tremendous problem, and I think there are some administrators who feel that the means test isn't worth the cost. I can't agree with that. It seems to me that it is worth the cost as a matter of principle, anyway, and I think, without any proper background or knowledge of it, it is worth the cost economically.

IV. The medical care of those who are able to purchase it by voluntary prepayment plans or by direct payment is the responsibility of the individual.

S. 545 states that it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status. Actually the bill provides for the establishment of plans for families and individuals of low income. As previously stated, there is nothing in S. 545 that would prohibit a State from applying the term "low income" to substantially its entire population except the limitation placed on available funds in section 77, page 16, lines 20–22. It is, therefore, again recommended that the term "low income" be defined.

V. Eligibility for receiving benefits under a program aided by Federal grants should be determined by the individual States.

S. 545 states that no plan or modification shall be disapproved by the Director of the Office of Medical and Hospital Care Services because the Director disapproves of the methods proposed. It also states that it is intended that the State shall devise in each case the methods by which this plan shall operate.

VI. The patient shall have free choice of his physician, group of physicians, clinic, or hospital from among those participating in any plan, provided that the physician, group of physicians, clinic, or hospital selected shall have the right to refuse to accept the patient.

Nothing in S. 545 as it is written is inconsistent with this principle.

VII. Physicians and other qualified persons rendering medical care should receive adequate remuneration for their services.

S. 545 leaves the amount to be paid physicians up to the States and presumably the fees would be adequate though minimal.

Out of the annual appropriation of $200,000,000, Massachusetts might receive $5,166,400. To this the Commonwealth would be compelled to add at least a like sum, giving a total of over $10,000,000. At the present time, this amount would be sufficient to insure 200,000 families in Massachusetts' voluntary medical and hospital care plans. This is figured on a wartime basis. Dr. Hayden perhaps could elaborate on that when he comes up.

Senator Murray. That is the Massachusetts Voluntary Medical and Hospital Care Plans. Is that right?

Dr. Bagnall. That is right.

Senator Murray. Have you made a study of those plans and could you explain them?

Dr. Bagnall. Dr. Hayden is following me, and he is the Medical Director of both the Blue Cross and Blue Shield, and I think he is eminently qualified.

Senator Murray. I see. I was going to inquire about the extent of care given under the Blue Cross Plans and whether or not the care is complete.

Dr. Bagnall. I am on the executive board of both corporations and chairman of the Central Professional Service Committee. I am sure Dr. Hayden can do a better job on that than I.

Senator Murray. All right, thank you.

Dr. Bagnall. It therefore might seem to approach an adequate amount with which to inaugurate the program in Massachusetts on a prepayment basis or otherwise. Right there it occurs to me to say that people figure on the basis of, well, the number of people ill. I think it might be said in cases of catastrophic illness, where the Taft bill comes in, that it doesn't happen any more than once in 6 years in the average family. Now, if those people are able to cover themselves by insurance, all right. There is a point that fits in there, that some people might not cover themselves by insurance if they were going to be taken care of in the Taft bill. I think that is a thought. But if only one person in six has a catastrophic illness in a year, then you don't take your total population; you take one-sixth of your population, then you deduct from that perhaps 20 percent on the top level who will be able to take care of themselves without insurance. I think that could be agreed on, and then you get down to perhaps 13 percent or less who are going to need subsidy under the Taft bill.

The Taft bill provides subsidy for those who are totally indigent and also for those who are medically indigent, and those who are medically indigent pay insofar as they are able to pay, so that the burden, if you analyze it in that manner, doesn't seem too great. It is feasible from a superficial approach, anyway, and I think it might be worked out.

Senator Smith. Do you think it is worth making an experiment along that line to see how we would come out?

Dr. Bagnall. Yes.

Senator Smith. That would take 3 or 4 years, I suppose.

Dr. Bagnall. VIII: The physician shall be free to elect or reject without prejudice participation in a medical care plan. The rights of the physician as to the choice of methods by which he is to be paid shall be fully protected.

S. 545 leaves the method of selecting and paying physicians to the States. Aside from the State advisory committee, which actually has no real designated powers, there is nothing to prevent the formulators of the State plan from establishing such methods of choosing and paying physicians as strikes their fancy. It is to be anticipated, however, that a program as important as this one would be worked out on a rational basis.

Senator Murray. Of course, the State advisory committee would have medical men.

Dr. Bagnall. That is right. In addition to the foregoing recommendations, the following are also submitted:

That Section 102, subsection (b), paragraph (4), page 4, shall be deleted, and that the following shall be substituted:

> make reports and recommendations with respect to the most efficient policies and methods for promoting the designated functions of the agency.

That section 104, subsection (c), page 9, be amended by striking out the words:

who has had at least five years of active medical practice and,

in lines 15 and 16.

That section 104, subsection (d), page 10, be amended by striking out the words "Surgeon General" in line 11 and by substituting the word "administrator."

That section 712 be amended to include a subsection (c), on page 21, which shall state:

If any State is dissatisfied with the council's action under subsection (b), such State may appeal to the United States Circuit Court of Appeals for the circuit in which the State is located.

That section 714, subsection (b), page 24, be amended by deleting the words "Surgeon General" from line 11, and substituting the word "Director."

We would like to emphasize the desirability of gradual evolutionary rate of expansion of plans for distribution of medical care. We think we are following logical lines in our own State. There will always be the group of medical indigents who are not able to meet the costs of major diagnostic problems or catastrophic illnesses. Perhaps the average family meets these situations only once in 6 years. These people at present are subsidized by the doctors and the hospitals.

Senator MURRAY. Doctor, right there, I have always understood that as a result of this situation a lot of people neglect to go and seek medical care and diagnostic treatment, and as a result of their delay, they finally find themselves in a condition that is practically incurable. That situation exists to some degree, does it not?

Dr. BAGNALL. It does exist to some degree, but it is exaggerated by some people. In my own community I don't see so much of that because the people who know me know they can come to me. On the other hand, there are some people with so much pride that they wouldn't come to me if they can't pay.

Senator MURRAY. Then, of course, there are other people who are not well-acquainted with the medical profession and they have a great hesitation to go and seek medical care or diagnostic treatment because they feel that they are seeking charity; they don't know whether they will be accepted anyway, and they simply hold back. There are other people who have families, who send their children to school, who feel they shouldn't do it. They feel that they should save the money for their family, and as a result, they neglect themselves. So it seems to me there should be some way of taking care of that kind of situation in order to reduce the cost for them through some sort of system, compulsory or otherwise, so that they may without hesitation be able to take care of themselves and their families.

Dr. BAGNALL. I am sure that is right. It occurs to me to emphasize the fact, though, that there is a difference between the utilization of medical care and the availability of medical care. There are a lot of people who wouldn't use medical care if you crammed it down their throats.

Senator MURRAY. They need education.

Dr. BAGNALL. That is right; and that is a part of the program to build on.

Senator MURRAY. Then a good deal could be done along that line, don't you think so?

Dr. BAGNALL. A lot more could be done.

Senator MURRAY. I don't recall in my school days ever having any of that advice. Of course, I lived in the horse and buggy days, and the medical profession then carried all of their equipment in a little black bag when they visited a family. There were no such things as hospitals in most communities. So that things have changed considerably now. We now have this very fine, highly developed medical care and treatment in this country that everybody should have if it is possible to get it.

Dr. BAGNALL. You remind me of something that I would just like to take a minute on. You get the impression from some men who come here that are specialists and have lived in the city and lived in laboratories all their lives and don't know the conditions in the field, down in the grass-roots level, and I will debate with anybody on that, because I know something about the grass-roots level.

I provide for my people the kind of care that I think they ought to have, and I think it is fairly good. I don't belong to a group. I am associated with a hospital, but I have my own informal group. If I have a patient that needs specialized care, urological care, eye care, ear care, whatever it is, I know where the specialist is who will provide that service and he will provide it for nothing or provide it for whatever the patient can afford to pay.

So I am not suffering. I am able to take care of most of the illnesses of my patients. They are not suffering and I am not suffering because I haven't at my shoulder, figuratively or literally speaking, basic metabolism apparatus, X-rays, and all those things. I can get them quickly enough, and it is perfectly feasible to practice medicine on that basis effectively. I just want to emphasize that.

Senator MURRAY. Yes; I think so. I think the medical profession has done a splendid job in this country. I know I came through fairly well. I am 71 years old and lived in a community where they had only one doctor when I was young, and in my own town of Butte, where I lived in later years, the medical profession there took care of everybody for every ailment they had and did a good job on them, and I am entirely satisfied with the medical profession. Among the best and dearest friends I ever had were my doctor friends in Butte.

Dr. BAGNALL. I would like to quote from the conclusions of the State advisory council, division of unemployment security of Massachusetts, presented after long and careful study, to the 1945 session of our legislature. I sat in on that committee for two afternoons. I think they worked for 2 years and they sat every second Thursday afternoon through that 2 years. Mr. Lambie, professor of government at Harvard, was chairman of that commission, and there were representatives of labor and industry and government, and so forth, and it was a very high-grade group, and these were their conclusions:

> While the council senses a strong desire for an extension of facilities to aid in meeting the costs of unusual or prolonged illness, it is not convinced of any pressing need or urgency for governmental compulsion in the Commonwealth of Massachusetts to accomplish it at this time in view of the growth and trend of development along voluntary lines.
>
> It was found on a spot check of the working population covered under the unemployment compensation law, which represents approximately 75 percent of the

> total working population in the Commonwealth, that 65.9 percent or nearly two-thirds (it is over 71 percent now) of the individuals were covered in their places of employment by some form of voluntary protection against loss of wages due to illness. * * *
>
> The present voluntary coverage in health and accident protection in Massachusetts, including cash payments for wage loss, is striking evidence of a consciousness on the part of employers, trade unions, private insurance carriers, and the medical profession for the "social security" of the people of Massachusetts and of what can be accomplished through coordinated efforts in the private enterprise system. The plans in existence cover this protection to a previously unbelievable extent. Most remarkable, also, is the extent to which the citizens have availed themselves of the opportunities afforded by the various individual and group plans. The Council would question the advisability of disturbing or perhaps thwarting the gains thus made, as the economic independence thus attained when the people meet these problems themselves is democracy in action.
>
> It may be questioned, for example:
>
> * * * * * * *
>
> 3. Whether anything but a major hazard should be provided for by governmental compulsion;
>
> 4. Whether governmental compulsion is necessary until such time as it is clearly demonstrated that private enterprise cannot assume the responsibility;
>
> Whether the role of Government should not be one of adding impetus to the establishment and expansion of private plans rather than in direct participation.

In conclusion, I would like to quote from an editorial in the New England Journal of Medicine on May 1, 1947:

> S. 545 seems to be, at least so far, the best framework on which to build the kind of health legislation that the country needs. It is to be hoped that, after conflicting groups have made the necessary compromises that are a proper mechanism for forging laws in a democracy, the foundation of a broad progressive system of medical care will be evolved.

Now that concludes my remarks. If there are any questions, I will be glad to try to answer them.

Senator SMITH. Senator Murray?

Senator MURRAY. I don't think so. I think the doctor has made a very excellent statement here. I agree with him about the evolution that is taking place, but you realize, of course, Doctor, that it was only as a result of the people of the country becoming very active in urging these things that they were able to get them. They had to arouse the Nation to the need for these things. For instance, workmen's compensation laws were bitterly opposed. They were called communism and socialism at one time, and since they have been put into operation, of course, it has been recognized that they are not. The workmen recognize now that it has been beneficial to them and a great help to the American people. That and other things that have been accomplished in this country have been of great help to us in meeting these problems for the lower income groups, and it has greatly improved the condition of the health of the people of this country. The health of the people of this country can be credited to a considerable degree to these improvements that have been made in the Nation.

With reference to health, food, and so forth, we are in a bad situation at the present time as a result of the war and as a result of the poor housing that we have, but I think in time to come, we will be able to accomplish great advances in that line also. I thank you very much for your testimony.

Dr. BAGNALL. I don't know whether I can quote it or not, but Elihu Root said at one time:

> You cannot make any progress in this world without overriding the satisfaction men have in things as they are and in which they have long been successful and content at heart.

Senator MURRAY. That is right. When I went out to Butte, they were making provision for the protection of the men in the mines. I used to know miners walking down in the street dying on their feet because of that deadly disease, silicosis. Nothing was being done for them. We had a terrible struggle in our efforts to develop ways and means of overcoming those conditions. So that everything we do, everything we accomplish in this country is the result of hard work and effort on the part of the people.

Senator SMITH. I think you will agree, Doctor, that probably the greatest advances in medical science that have been made in this country were the freedom of action that our research men and doctors have been able to have had in going after various hidden secret trails, and you wouldn't trade our American free system probably for any other system in the world, even under the supposedly efficient Mr. Hitler or Mr. Stalin.

Dr. BAGNALL. No. I am tempted to prolong my remarks by saying something about the Veterans' Administration. I think we all agree that the whole Veterans' Administration, where it has improperly correlated medical service, was pretty bad, and I am sure that under General Hawley, the medical service of the present Veterans' Bureau is superb, and I know the spirit that the men who work with him have, and just as soon as, if and when, he is persuaded that he can't carry the ball in this manner, I think he wouldn't carry on any longer. But that is a demonstration there of the value of the present system. Perhaps it grows out of the spirit of the emergency. Perhaps we could relax into the rut which got us into such a bad situation with the old Veterans' Bureau. But I know the men in my profession who are working with the Veterans' Bureau now are working with a fine spirit and they are not objecting to working with the Government at all, so long as things continue that way. Sometimes things threaten to go in the wrong direction.

Senator SMITH. Thank you, Doctor. We are very grateful to you. The next witness is Dr. Charles G. Hayden, medical director of the Massachusetts Medical Service & Massachusetts Hospital Service, Inc.

Dr. Hayden, will you make a brief statement for the record before you begin your testimony as to your background, experience, and so forth?

## STATEMENT OF DR. CHARLES G. HAYDEN, MEDICAL DIRECTOR OF MASSACHUSETTS MEDICAL SERVICE, MASSACHUSETTS HOSPITAL SERVICE, INC.

Dr. HAYDEN. I am a physician licensed to practice in Minnesota, where I graduated from the university. I am also licensed to practice in Massachusetts. I am a member of the Massachusetts Medical Society and I am associated with Dr. Bagnall on the subcommittee on national legislation of the society. I spent 4 years in the United States Public Health Service during the war. For approximately the first 2 of those 4 years I worked with the Third Service Command in Baltimore. The second 2 years I was in the Coast Guard, spending most of my time aboard a large transport, the U. S. S. *Wakefield*. I have been with the Massachusetts Medical Society in Massachusetts serving the Blue Shield and Blue Cross for about a year and a half.

My interest in voluntary prepayment plans goes back to my early days as an undergraduate at the University of Minnesota, where during my summer vacation time I sold Blue Cross. Mr. Van Steinwick, who is the director of the Philadelphia Plan at the present time, set up a plan in St. Paul, later extended it to Minneapolis, and subsequently throughout the entire State of Minnesota. It was one of the very early plans in 1933, 1934, and 1935, and during my summer vacation, I sold Blue Cross.

I became very much interested in this movement because of the fact that most of my background—that is, my medical background—prior to the time that I went into medicine was in the field of social science. I have degrees in anthropology and sociology. I am practically inclined to practice medicine on a wholesale basis rather than on a retail basis. I am only sorry there are not more physicians with the kind of background and interests that I have to take hold of some of these medical-care plans, because I think they are a very fine method of meeting some of the problems which we are now faced with in the field of medical care. Is that enough, sir?

Senator SMITH. As far as I am concerned.

Senator MURRAY. That is fine.

Senator SMITH. That is fine. Go ahead.

Dr. HAYDEN. In Massachusetts we have a voluntary hospital-care plan and a voluntary medical-care plan. The Massachusetts Hospital Service, Inc., Blue Cross, covers approximately 2,000,000 persons—about one-half the population of the Commonwealth. The Massachusetts Medical Service Blue Shield, a much younger organization, covers 600,000 persons, and its rate of enrollment is increasing rapidly. At the present time we are enrolling in our medical-care plan at the rate of between twenty-five and thirty-five thousand persons per month, which is pretty rapid.

Senator SMITH. Would you say if a person carried both the Blue Cross and the Blue Shield that it is a general health coverage for an individual or a family? Is that what you aim to do?

Dr. HAYDEN. I think I bring that out, Senator, if you will bear with me just a moment. I think I have covered that point.

As of June 1, 1947, Blue Cross, which offers a semi-private contract and a ward contract with a family income limit of $2,500, extended its program to cover all services customarily furnished and billed by the hospital during a period of 120 days per admission. In other words, the original Blue Shield program provided benefits for surgical and obstetrical services rendered to a patient in a hospital. Massachusetts has the third oldest plan. The two other plans, Michigan and California, that started out before Massachusetts, had a broader scope of benefits, and they ran into some trouble because there was no actuarial experience on which to establish their rates. They didn't know what their expenses were going to be, that is, how much it was going to cost them to provide the kind of benefits they provided. So the men who set up our Blue Shield program in Massachusetts took cognizance of the fact that they had had some trouble in California and Michigan and they limited the benefits to surgical and obstetrics in the hospital.

Now as of June 1, we have extended that program. Our operations during the past 3½ to 4 years have been eminently successful, both from the standpoint of giving benefits to subscribers and from our financial experience.

Now at the same time, Blue Shield extended its program of benefits for surgical and obstetrical services rendered in the hospital to include benefits for medical services rendered in the hospital and for surgical and obstetrical services rendered outside the hospital.

So in our medical care plan as of June 1 last, we are providing benefits for every kind of service except medical, that, is, nonsurgical, service in the home and office. There are some actuarial headaches involved in providing that kind of service, and until we get more experience in our approach to providing nonsurgical service outside the hospital, I think we will continue on that basis.

Senator SMITH. There would be danger there, wouldn't there, whereby if people felt they could go any time they wanted to they would abuse the privilege?

Dr. HAYDEN. That is right. If you have a lady or a gentleman who is psychoneurotic, who has an ache or a pain every time and has this kind of coverage and felt that he or she could call the doctor any time, the doctor would be glad to go, because he would get $2 or $3 every time he saw the patient. You would have the patient taking it out from one sack, the doctor taking it out from the other sack, and we would be sitting in the middle holding the sack. That was the experience in California and Michigan, as Mr. Ketchum told you the other day.

We think there is an approach to that kind of service, but we are not ready to experiment with it at the present time because we have just bit off a pretty large chunk by extending our benefits as of June 1 last.

Senator SMITH. Do you think it might be better, then, for the States to experiment with that rather than to try to have an over-all plan to cover the country as a whole?

Dr. HAYDEN. I don't think I understand your question.

Senator SMITH. Would it be better to have this broken down into States and let each State try to work out its solution of that particular problem rather than have an over-all plan prepared by the Federal Government?

Dr. HAYDEN. Oh, yes; I don't think there is any question about that. We are going along very nicely in Massachusetts in an evolutionary manner. Dr. Bagnall expressed the fact that we believed in evolution rather than revolution, and we are doing very nicely with our medical care plan, and especially with our hospital care plan which has been in operation for 10 years and covers half the people of the Commonwealth; and what we are going to be interested in in the future is some mechanism that will provide benefits for these people that we can't reach, that just can't afford the premiums they would have to pay for our medical care and hospital care coverage.

Senator SMITH. That is one of the big problems that we are considering in this bill.

Dr. HAYDEN. That is the purpose of this bill, as I understand it. It isn't exactly what it says, as Dr. Bagnall has pointed out, but I don't think that that intent can be made more specific.

Senator SMITH. Now, Doctor, one more question. When you speak of your Blue Cross plans, you are speaking in terms of the Blue Cross in Massachusetts and not the National Blue Cross. Is that right?

Dr. HAYDEN. I am only talking about Massachusetts, but what we do in Massachusetts can be duplicated any place else in the country.

Senator MURRAY. Doctor, regarding Massachusetts—I have a book here entitled "Voluntary Prepayment Medical Care Plans, 1947," and on page 32, it specifies the benefits that are accorded under that plan.

Dr. HAYDEN. That is right, but you have got the benefits there. If I may interrupt, Senator, this program that I am talking about went into effect on June 1, 2 or 3 days ago, you see. We have a surgical and obstetrical program, and that is the program that is outlined there, but as of last June 1, we have extended this program.

Senator MURRAY. Now before that plan went into effect, the Massachusetts plan did not provide preventive medical care and there were no physical examinations, no drugs or laboratory examination, no X-rays in medical cases, and only $15 worth in surgical cases; no medical care in hospitals for illness such as the flu or pneumonia or anything that didn't require surgery; no doctor's visits in the patient's home at all and absolutely no medical care in the doctor's office. Have you overcome all those deficiencies?

Dr. HAYDEN. We haven't overcome all those deficiencies, but we have overcome a good many of them. As I explained a few moments ago, Senator, when you start a program of this sort you have got to know where you are going and you have got to be sure that you are going to have enough money to provide the kind of benefits that you undertake to provide. In other words, you have got to do what your contract says, and if you don't, the commissioner of insurance is right on your neck and asking why you are not doing it that way.

When Massachusetts Medical Service was established there was no data available as to this kind of approach to health problems except the small amount that had been accumulated by California and Michigan, which had been in operation a year or two. Now, you see, we have been in operation for about 4 years, and we know better what we can do and how far we can go with what we can charge the public. So our original program that you just outlined there, which was restricted on surgical and obstetrical in the hospital, has been extended now to include medical, surgical, and obstetrical—in other words, anything in the hospital. X-rays, of course, are paid for by Blue Cross supplementing the Blue Shield program, and for surgical and obstetrical services rendered outside the hospital. So the only thing people in Massachusetts who have coverage in both of these plans will not be covered for are nonsurgical services rendered out of the hospital—medical services. That is the only thing they will be covered in the hospital for, medical, but not outside the hospital.

Senator MURRAY. Are you furnishing a statement to the committee that would explain exactly what the Blue Shield plan is?

Dr. HAYDEN. Yes, sir; as I say, as of June 1, 1947, Blue Cross, which offers a semiprivate contract and a ward contract with a family income limit of $2,500—that is, those families who earn less than $2,500 are eligible for this ward contract which sells at a reduced rate—extended its program to cover all services customarily furnished and billed by the hospital during a period of 120 days per admission. That gets into the field of chronic care when you give them 120 days.

Senator MURRAY. You are just starting off with that plan now?

Dr. Hayden. June 1; that is right. On the basis of our past experience we have determined we can safely go into this expanded coverage.

Senator Murray. So you are in an experimental stage now.

Dr. Hayden. If you want to call it an experimental stage. I think we are pretty sure of where we are going. We have made studies of what our utilization is going to be. We know what our past experience has been and we know what the past experience of other Blue Cross plans have been. There isn't any question but what we are on safe ground and are going to be all right with this program.

Senator Smith. How many years of past experience have you had?

Dr. Hayden. In Blue Cross, about 10; in Blue Shield, that is the Medical Care Plan, about 4.

Senator Murray. Prior to the inauguration of these voluntary plans you are talking about, there was general opposition in the country amongst the medical profession against these voluntary plans. Is that not true?

Dr. Hayden. I wouldn't be qualified to say.

Senator Murray. There was no effort in your State to put them into effect until 4 years ago, you say.

Dr. Hayden. That is true. The program started there 4 years ago. Actually, they were thinking in terms of this kind of program in '38 and '39. Of course, I wasn't there. I have only been there a year and a half. Dr. Bagnall can perhaps tell you of some of the thinking and exploration that went into the early consideration of this program. He was there.

Senator Murray. Efforts on the part of groups in some parts of the country to establish programs of this kind met with litigation, did they not?

Dr. Hayden. They may have. I really don't know. According to the New York Academy of Medicine, the problem of providing medical care for the medically indigent and others really wasn't recognized as a problem until about 1915, and then no adequate studies of the problem were made until the committee on the costs of medical care made their study in the last part of the twenties. Then again, the Public Health Service came through in about '33 or '34, I believe, with another survey. The American Medical Association, of course, not too long after that, came along with suggestions that these programs be worked out in the individual States on an exploratory basis. So I don't see how the American Medical Association or the medical profession generally can be too harshly criticized for the action or, as you say, the inaction that has taken place in this field. After all, we didn't know what the problems were only until about 10 years ago, actually, where the needs were and it is one thing to say, well all these people have been sick for a long time and haven't had adequate care, but another thing to demonstrate if that is true. If it has been demonstrated, it has only been demonstrated 10 years.

At least 5 years ago, the American Medical Association took steps to authorize its State societies to go ahead with these programs on an experimental basis. So I am not very much in sympathy with criticism of the medical profession generally in this problem. When we think in terms of this problem, we are thinking in terms of a generation or two. The American medical profession in this country has been on the ball for the period of a decade.

Senator Murray. Of course, I am not criticizing the medical profession for any failure on its part to work out those problems. All I am saying is that in the normal evolution of medical care in this country these conditions were developing and they had been developing over a considerable period of time.

Dr. Hayden. Since about 1915.

Senator Murray. All of a sudden it became obvious to the American people that something should be done about it, the same as in every other walk of life. You recall that for a great many years, the stock exchanges in this country were operating on a basis which resulted in the cheating and defrauding of the American people of millions of dollars every year, and it was not until the crash in Wall Street in 1929 that we began to realize that something should be done about it. So these things come on all of a sudden at times. We discovered in the investigations carried on by the Senate Banking Committee here following the depression that the American people were being constantly defrauded and cheated out of millions of dollars in securities manipulations. I know doctors in my own town, who were very rich men, and who lost their entire fortunes.

So again in this situation here, we discover that the evolution in the medical care of the people of this country was not taking care of this situation. Something should be done about it. Then we begin to agitate for some plans. We are opposed at first; then finally they begin to recognize that something might be accomplished in the way of either compulsory or voluntary plans. So we are in a process of studying this thing. We need the help of the American medical profession to assist us in working it out. I think that a good many of the doctors are taking a great interest in this matter. I think they can be very helpful to us in working it out finally.

Dr. Hayden. Well, now, let us see. We will go down to the bottom of this page.

The affairs of the Massachusetts Blue Shield are directed by a board made up of one-third physicians and two-thirds laymen. At the present time representation is as follows: Internist, roentgenologist, two general surgeons, two personnel managers, a representative of the CIO, a representative from the A. F. of L., a department of labor and industry representative. I might say that the CIO representative has been on the board for a number of years but he is now the head of the department of labor and industry, Commissioner Boyle of Massachusetts. We have another representative of the department of labor and industry as well as a banker and three industrialists and a hospital administrator.

Senator Murray. Do you think that is very satisfactory?

Dr. Hayden. I think it needs to be that way. We have a million-dollar enterprise in Blue Shield now and you have got to have the kind of guidance that you get from people who are experienced in handling large sums of money. That is why we have the industrialists and the banker. Similarly, when you sell a program of this sort to thousands and thousands of people, you have to know what reactions are and you get that by having representation on your board of people who are constantly in touch with their own needs, the labor people and so forth.

Senator MURRAY. I think you are right, Doctor, and I think that same system should be applied to all parts of the country and to all plants.

Dr. HAYDEN. It has been worked out very well and we in Massachusetts are happy with it.

Senator SMITH. Your director—or I should say you are the director working with this board, as I understand it?

Dr. HAYDEN. I am the medical director of the Blue Cross and Blue Shield.

Senator MURRAY. You do not find any difficulty working out the plan there? You get assistance from these other people that are not professional on that committee?

Dr. HAYDEN. That is right.

Senator MURRAY. They give you good advice?

Dr. HAYDEN. I want to qualify that a bit by this next statement here. Although changes in rules and regulations affecting medical matters must be formally initiated by the physicians on the board who constitute a central professional service committee, the lay members customarily discuss such matters and related motions have always been subjected to action by the entire board. When you talk about enrolling thousands of people, it is important to know their attitudes toward the plan, and when you are talking about what you are going to do with $600,000 or $700,000, you want to investigate and be sure the people understand this thing and by and large it is not the doctors that understand those things.

Senator MURRAY. And at the same time the public becomes convinced that they are getting a square deal and everything is being operated on a fair and equitable basis.

Dr. HAYDEN. That is right. While medical matters are in the hands of the physicians on the board, these concepts are always discussed by the whole board. Nobody is trying to hide anything and we sometimes get from laymen certain viewpoints that are helpful even as regards medical matters.

Under the Blue Shield Enabling Act, the Commissioner of Insurance must approve in writing all subscription agreements, participating physician agreements, subscription rates and schedules of fees. He may also limit acquisition and administration costs and require that a special contingent surplus be accumulated and maintained. Inasmuch as the Commission represents all the people of the Commonwealth and because the Blue Shield board of directors is made up of two-thirds laymen, it would seem that subscriber interests are well protected.

Senator SMITH. It refers to the Commission of Insurance?

Dr. HAYDEN. Of the Commonwealth of Massachusetts.

When Blue Shield was established two categories of subscribing members were designated: unlimited or under-income, and limited or over-income. And if you could think of better terms we could use, we would be delighted to have you do so. However, an unlimited member was any subscribed without member dependents whose annual income was $2,000 or less or any one of a family group the total annual income of which was $2,500 or less. A limited member was one whose annual income exceeded these respective amounts.

For such services as are listed in the subscriber's certificate the unlimited member is subject to no additional charge over and above the Blue Shield fee schedule allowance. The limited member, however, is subject to an additional charge privately agreed upon by the patient and physician.

Senator SMITH. Then you designate so your doctor dealing with a patient knows whether it is under-income or over-income so as to know whether to charge more or not.

Dr. HAYDEN. We ask the application to cover that but it is impossible to keep such information current so you can see it actually resolves itself into a question for the physician to determine at the time of the visit. That is why I think a means test can be worked out. I cannot get concerned over a means test.

Senator SMITH. In Massachusetts, it means $2,500——

Dr. HAYDEN. No; that is not right. The people in this under-income category below $2,500—and incidentally we changed those requirements and I will go into that in a minute—by families under $2,500, they are still able to buy this protection, you see. Now, the medically indigent in Massachusetts, as far as I am concerned, are those who cannot afford to pay the rates for the under-income.

Senator SMITH. Cannot pay the payment at all—the premium.

Dr. HAYDEN. They cannot pay the premium at all. They are the kind of people S. 545 should take care of. They can buy the Blue Shield and Blue Cross ward plan, these under-income, and that would run in the neighborhood of $4 a family a month.

Senator SMITH. You take both services.

Dr. HAYDEN. Take both services and we are getting more and more participation of employers whether they either pay the whole freight or some portion of it, but these people are not medically indigent in any sense, so far as our program is concerned. You have got to get down to the people who cannot afford to be even under-income Blue Shield.

Senator SMITH. As I gather it, you have three classes. You have your top class, financially, those who pay the premium the same as everybody else, but they can be expected to pay additional fees to the doctor, and that is the agreement with them—that they agree to pay additional fees.

Dr. HAYDEN. That is right.

Senator SMITH. You have your so-called under-income category who pay the premium, and then the medically indigent for whom some measure has to be provided to pay the premium.

Dr. HAYDEN. That is exactly right. That is where S. 545 comes in for those people down below our under-income level.

Certainly we would never agree that a family that makes $2,500 or $3,000 in Massachusetts is medically indigent. We would not agree to that at all for the ordinary run of disease.

According to statistics furnished by the Massachusetts Department of Labor and Industry, the original Blue Shield income limits blanketed 80 percent of the wage-earning population into the unlimited, under-income category, where they were eligible for service benefits without additional charge. Because of the increased wages during and following World War II, this percentage dropped to about 65. Consequently—and this is important because it represents an action on the part of the doctors that is highly commendable, so far as I am concerned—the Council of Massachusetts Medical Society, after studying the problem, voted to increase the limit for the family to $3,000, thus restoring the original relationship—that of 80 percent in the under-income bracket.

Now, inflation affects physicians as well as patients, yet the Massachusetts Medical Society voted to increase the income limit for the family without asking for a compensatory increase in the Blue Shield schedule of fees in which, incidentally, an appendectomy is listed at only $75. In other words, they voted to increase the income limit to $3,000 without asking for any increase in the schedule of fees whatsoever.

More than 90 percent of the physicians in Massachusetts are participating, under contract, in Blue Shield. They are doing so not because they fear compulsory governmental health insurance but because they individually and collectively recognize a fundamental social and moral obligation to provide the people of Massachusetts with the best possible medical care on a basis commensurate with their economic abilities.

Blue Shield has long been cognizant of the fact that there is a certain segment of the population which it can never reach unaided; consequently, a supplement such as is embodied in S. 545 is vitally necessary to complete the medical care picture in Massachusetts.

Senator SMITH. Do you feel if we can make provision for the medically indigent by such a measure as S. 545 that in Massachusetts at least you will have the program pretty well covered? Of course, your Blue Shield does not yet take care of medical attention in the homes or in the office.

Dr. HAYDEN. Medical, nonsurgical; it takes care of surgery or delivery of a baby in the home or office or anywhere else outside the hospital.

Senator SMITH. Then to take a State like Massachusetts, having worked out an interesting plan here and given careful study to it, what you need is some sort of assistance, at the Federal level, probably, such as grants-in-aid under such a bill is S. 545 to take care of the indigent and the medically indigent, and then the further reach for over-all coverage for medical care in home and office.

Dr. HAYDEN. I do not think we need a subsidy for homes and office care; I think the amount of home and office care that is necessary, the amount of nonhospitalized, nonsurgical, nonobstetrical services that might be rendered by Dr. Bagnall, for instance, in a patient's home or office is relatively inconsequential and for the most part the people can pay for it.

Dr. BAGNALL. I agree.

Dr. HAYDEN. For the most part, the people can pay for it on an individual basis. If they have a catastrophic experience, they can go in the hospital. So if they really get sick with pneumonia, they can go to the hospital; but for these ordinary home calls where the baby is choked up, Dr. Bagnall comes over and they can pay $2 or $3 or whatever Dr. Bagnall charges; that is something they can handle themselves: I would not say that we need any subsidy at all for the nonsurgical services under our Blue Shield program.

I think one of these days, as our experience accumulates, we will be able to provide those services under our plan.

So far as I am concerned, the only people that I would be interested in having you worry about are people that cannot afford to belong to our plan at all; they are the medically indigent, and the totally indigent, and I think those terms have to be very carefully defined because, as Dr. Bagnall pointed out, it is conceivable that in some States the administrator could make everybody medically indigent. It will not happen in Massachusetts because our relationships with the department of health are excellent. We get along very well. But it could happen in some places if they had a program such as ours, a Blue Shield plan of income limit of $3,000 or more, they could say, everybody up to $3,000 is medically indigent and who could say "Nay"? There is nothing in the bill to stop them. We hope they will not do it in Massachusetts. But some unscrupulous people might get hold of the plan in some other States and just declare everybody who makes less than $3,000 a year as being medically indigent and not able to pay his own way.

I think that has to be very carefully protected in this bill now and it is very hard to define, but it has to be made.

Senator SMITH. Have proper precautions been taken in the administration of this?

Dr. HAYDEN. There is no question about the intent of the bill.

Senator SMITH. You divide your people now between those $3,000 and up and $3,000 and down, the instance you gave under the Blue Cross coverage. Do you find there is much protest of people in the $3,000 and up class for having to pay additional after they pay a premium for service?

Dr. HAYDEN. No, sir.

Senator SMITH. They understand that?

Dr. HAYDEN. It is sold to them on that basis. We advertise in the newspapers. All of our advertising, all of our promotional material, stresses this fact. We want that to be clear because it is fundamentally important.

Senator SMITH. Is there any ceiling on what doctors can charge on the doctor-patient basis?

Dr. HAYDEN. We have no control over what the doctor charges the patient over and above——

Senator SMITH. A private contract?

Dr. HAYDEN. Privately agreed upon. We do not feel that we should in any way restrict the doctors from making an additional charge to over-income people. We expect the doctors not to charge them any more than they would ordinarily charge them, giving them a credit of the Blue Shield allowance, and that is essentially what happens.

Now, there are doctors and doctors. There are some lawyers, I am sure, who like to gouge their clients, and I am sure there are some doctors likewise, but the people learn quickly who they are and they tend to divert their business to other physicians who are just as well or perhaps better qualified. That is true in any walk of life.

Senator SMITH. I assume you have published statements which you give to people when you are soliciting?

Dr. HAYDEN. We spend a lot of time on promotional material.

Senator SMITH. Have you a sample, a simple summary of your hospital program with these changes, and so forth, that you could put in the record as part of the testimony? I would like very much to have it.

Dr. Hayden. About 6 months ago, to complete the story on Blue Shield, taking up all of its aspects, I prepared material the final revision of which I have just sent to the printer. It should be back in a week or two. Would it be too late?

Senator Murray. Is it a concise statement of it?

Dr. Hayden. It is a little booklet about so big [indicating].

Senator Smith. We do not want to put too much in the record.

Senator Murray. I shall be glad to have a copy.

Dr. Hayden. Some of it is in here. I will be very glad to write a short summary.

Senator Smith. Do I understand that this sort of classification—what you call the under-income and over-income—applies only to Blue Shield, or does it apply to Blue Cross as well?

Dr. Hayden. Blue Cross provides benefit for only semiprivate accommodations for people who buy that coverage. A family earning less than $2,500 is eligible, under Blue Cross, to buy the ward plan, and they would go into a ward accommodation, but they do not have over- and under-income categories; they buy either semiprivate or they buy ward accommodations, depending on whether the family earns more than $2,500.

Senator Smith. Senator Murray, have you any further questions?

Senator Murray. I have a statement here I believe I could comment on, something appearing in the Boston Daily Globe, May 2, reporting a statement made at the annual meeting of the Massachusetts Medical Society by Dr. McKettrick, who is a Boston surgeon. Incidentally, I understand that Dr. McKettrick is a well-known physician up there; is that true?

Dr. Hayden. An outstanding physician; an outstanding scholar; an outstanding gentleman.

Senator Murray. A member of the board of trustees of the National Physicians' Committee?

Dr. Hayden. He may be; I do not know.

Senator Murray. That committee reported spending over $357,000 for the last 9 months, not for medical care but to lobby against national health insurance. The doctor is reported to have stated that 84 percent of the population of Massachusetts had incomes of less than $3,000 a year and could not pay the cost of serious illness; that 69 percent earned less than $2,000 and this does not include the unemployed. The Blue Shield plan of Massachusetts, providing surgical and obstetric care, only covers 13 percent of the population. Dr. McKettrick's statement points out that Blue Shield covers only 13 percent instead of the 69 percent which everyone agrees needs health insurance. Only 13 percent instead of 89 percent which even the AMA agreed needs insurance.

Moreover, I have just been informed that 16 independent railroad organizations working on the Boston & Maine Railroad have just completed a study of various plans. They have jointly recommended to their membership that Blue Cross and Blue Shield coverage be discontinued. They found that a commercial insurance company frankly making good profits offered more benefit for a lesser cost than did the Blue Shield plan which is labeled nonprofit but where doctors determine how much care they will give and at what price. You may comment on that, Doctor, if you wish.

Dr. HAYDEN. There is no question but what approximately 80 percent of the wage-earning population in Massachusetts is in the so-called underincome bracket or category.

Now, as to the number of people we cover, 13 percent as Dr. McKettrick suggests—we cover 600,000 people at the present time.

During the last 2 years our enrollments have increased at a rapid rate—in Blue Cross, 2,000,000 people which is half the population of the Commonwealth, because they have been in operation 10 years. We have been in operation for only 3 or 4 years. We are enrolling between 25,000 and 35,000 persons per month. Give us a little time until we educate these people. They are people who have felt, well, I have got Blue Cross; that gives me lots of protection. Selling a medical-care program on the type of a hospitalization program requires, as you suggested yourself, education. These people have got to be educated up to the value of insuring themselves against the hazards of medical cost as part of the hospital costs.

Now, we think it will not be very long until we will have half the population enrolled in Blue Shield, too, 2,000,000; and, of course, Blue Cross is continuing to enroll and I do not think we will ever get to the place where we will include all of the population because there are the segments down below we cannot touch, the medically indigent. That is why we need S. 545.

Senator MURRAY. People are dropping out and coming in again, is that not true? People carry it for a while and then drop out and come back.

Dr. HAYDEN. I expect there is a good deal of that. If they change places of employment, of course, they can continue coverage. Once a member you continue to maintain membership—continue to be a member.

Senator MURRAY. You do not think this is a serious situation where these 16 independent railroad organizations working on the Boston & Maine Railroad——

Dr. HAYDEN. That is the Boston & Maine—that is a situation that I would not particularly care to discuss, because there is much more to that situation than meets the eye. If you go up and ask the employees of the Boston & Maine what they think about Blue Cross and Blue Shield and the commercial program being foisted upon them, I think you get a very different impression than you get from reading that newspaper slip there.

In fact, we have had a lot of these Boston people screaming that they want to keep Blue Cross and Blue Shield, the heck with this commercial program. There are a number of facets involved in this thing and Boston and Maine pays part of the freight and the union is in on it and there are lots of things behind the scene that are not all in the open and above board and not known to me and I would not care to discuss it any further.

Senator MURRAY. And it would be necessary also to investigate the commercial insurance company and find out just exactly what they render or what they give.

Dr. HAYDEN. There is not any insurance company offering private insurance that can offer service benefits to 60 percent of the people in the Commonwealth as we are doing in Massachusetts where the doctors take our fee and call it quits and do not make additional charges.

We could sit here all day and talk about the merits of commercial insurance and this kind of approach. We have seen commercial medical plans on the Continent where they were compulsory, and in England, and I think we have got to a place where commercial insurance understands what the situation is. Here, physicians are accepting a fundamental responsibility to provide care for the people of the entire United States on a regional or local basis. While over there, there are third parties not sympathetic either to physicians or people and the thing broke down. There was not an alternative. It would be the same thing here. But the doctors are beginning more and more to recognize this fundamental responsibility, that is the fundamental difference and it is very fundamental, very important.

I do not think this could be done by a private insurance company. I think if the private insurance companies ever took over this program—of course they would not in this country—it would only be a short step to your kind of a program.

Senator MURRAY. I suppose the incentive for some people to seek the private insurance companies was because of the deficient coverage of some of these plans.

Dr. HAYDEN. No; you would be surprised how many of these large enterprises have directors who are also directors of insurance companies.

Senator MURRAY. We had this problem or discussion up here before in connection with Michigan, I believe, a year ago and of course I can see how it would be more desirable to have perfected plans such as you have suggested, rather than attempt to handle it through insurance companies.

Dr. HAYDEN. These defections when a group goes over to private insurance companies—that does not disturb us. That happens time and time again; they turn around and come back. Insurance companies just cannot possibly give the kind of experience we give and it is a matter of experience.

Senator MURRAY. Trying to find where the most effective protection can be gained and if a voluntary or compulsory system is finally evolved, of course they will go for that as they have in some other parts of the world.

I have heard the compulsory system spoken of, the one in New Zealand, and criticized very severely before this committee on different occasions; yet I have had letters from the medical profession there sent me voluntarily. Doctors having read in the American Medical Association's Journal criticisms of their plan have written me complaining about the misrepresentation. I received just such a letter the other day in which a New Zealand doctor informs me that they are perfecting their system and that no one in their country would want to have it repealed.

Dr. HAYDEN. I think if you have just a handful of doctors as you might have in New Hampshire or Vermont or Maine, you can put on any kind of a medical-care program you want to, compulsory or any other kind. You have few doctors and by calling them all in and giving a good holler from the back stoop you can talk about what you want to do and how you want to do it and you can keep up the quality of care; but when you are talking about the United States of America, you are talking about an entirely different problem.

Senator MURRAY. Of course, you realize that any plan depends upon its efficient administration. You can make a bad plan work pretty well if you have a good administration of it and you can make a good plan work very poorly.

Dr. HAYDEN. That is true; but the truth comes out ultimately.

Senator SMITH. Doctor, you would probably see some difference in the New Zealand problem with a population of something under 2,000,000 and the United States with 140,000,000. The two present rather a different problem.

Dr. HAYDEN. There is not much of a basis for comparison and analogy when you talk about New Zealand and the United States.

Senator MURRAY. The point I was making was not an attempt to compare them and say that we should have the exact system they have in New Zealand; I was calling attention to the fact that the New Zealand plan had been misrepresented.

Dr. HAYDEN. That might be true.

Senator MURRAY. We take sides in this country on every issue.

Dr. HAYDEN. That is why we are a democracy; one of the nice things about a democracy.

Senator MURRAY. We finally come to an understanding at some stage of the game.

Senator SMITH. I think we all agree, Senator.

Thank you, Doctor. We appreciate your appearing here.

The next witness is Ernest R. Geddes, member of the assembly, California State Legislature.

Mr. Geddes.

(Subsequently Dr. Hayden addressed the clerk of the committee as follows:)

MASSACHUSETTS HOSPITAL SERVICE, INC.,
MASSACHUSETTS MEDICAL SERVICE,
*Boston 11, Mass., June 30, 1947.*

Mr. PHILIP R. RODGERS,
*Clerk, Senate Committee on Labor and Public Welfare,*
*Senate Office Building, Washington, D. C.*

DEAR MR. RODGERS: Transmitted herewith is the material requested by the Subcommittee on Health at the time Dr. Elmer S. Bagnall and I presented our testimony on S. 545.

Cordially,

CHARLES G. HAYDEN, M. D.,
*Medical Director.*

## MASSACHUSETTS MEDICAL SOCIETY—TESTIMONY ON S. 545

(Dr. E. S. Bagnall, Groveland, Mass.; Dr. Charles G. Hayden, Brookline, Mass.)

The Massachusetts Medical Society favors the ultimate creation of a Federal Department of Health with a physician as Secretary in the Cabinet. If this cannot be accomplished at the present time, the society believes that an independent health agency would constitute a marked improvement over the present arrangement in which some 30 constituent units in some 13 Federal departments and agencies are engaged in various phases of health work. It is, therefore, recommended that section 2, subsection (d), page 2, of S. 545 be amended by striking out the word "further" in line 17, and by placing a semicolon and the word "and" after the word "funds" in line 20; and that section 2, page 2, be amended by adding a new subsection "(e)" which shall state, "that health and medical functions, being of a highly technical nature, do not lend themselves to administration by or under a nonmedical agency."

While the Massachusetts Medical Society recignizes the need for Federal grants-in-aid to States to subsidize public health programs for all the people and medical care programs for the medically and totally indigent, it believes that careful definition of what these programs are to encompass both in the way of benefits and persons is necessary.

In February 1946, the Massachusetts Medical Society adopted a set of basic principles which should govern medical-care plans. In the light of these principles, S. 545 has certain strengths and certain weaknesses.

*I. "The objective of adequate medical care in our free society is to make available to everyone—regardless of race, color, creed, financial status or place of residence—every known essential preventive, diagnostic and curative medical service of high quality. The attainment of such medical care must necessarily be an evolutionary process that will require the cooperation of all concerned over a period of years"*

S. 545 states that it is the policy of the Federal Government to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status. Actually, however, the bill is designed to assist the States to provide general health, hospital, and medical services for families and individuals with low income. It is suggested, therefore, that section 2, subsection (c), page 2, be amended by striking out lines 15 and 16, and substituting the words "services to every individual who is unable to obtain such services because of his low income;". It is also suggested that the phrase, "general health, hospital, and medical services," be clarified.

II. *"The success of any plan for medical care is dependent on the mutual cooperation of the public, those rendering professional services and the administrative agencies. This coöperation can be obtained only if those rendering the services are convinced that they will have a continuing authoritative voice in the formulation and execution of policies and plans, thereby assuming their proper share of responsibility"*

On the national level S. 545 is to be administered by an independent agency headed by a licensed physician appointed by the President by and with the advice of the Senate. Provision is made for a consultative National Health Council of eight members appointed by the Administrator. Four of the members must be doctors of medicine. In the event that a State plan or modification thereof is not approved by the Director of the Office of Medical and Hospital Care Services, the State may request a hearing before the Council which may affirm or overrule the decision of the Director. This is the only real power that the Council has.

On the State level S. 545 is to be administered by the State health agency which may, however, utilize the services of voluntary, nonprofit organizations. There is to be an advisory council appointed by the Governor which must include representatives of the State medical association, State hospital association, voluntary nonprofit medical and hospital care plans and other groups interested in the improvement of medical and hospital services and in the better distribution thereof.

Should the Director of the Office of Medical and Hospital Care Services at any time determine that a State agency is not complying substantially with the provisions of a plan previously approved, that Federal funds have been diverted from the purposes for which they were allotted, or that the State and its governmental subdivisions have failed to provide at least as much money as they have received from the Federal Government, he must withhold further certification. In such instance the State may appeal to the Federal courts.

While it is the obvious intent of S. 545 to solicit enlightened lay and professional guidance on both the Federal and State level, there is nothing in the bill guaranteeing such an arrangement. It is therefore recommended that section 104, subsection (d), page 10, be amended by adding the following sentence after the word "Council" in line 16: "The head of the Office of Maternal and Child Health shall take cognizance of and be guided by the advice of the Advisory Council."; that section 106, page 11, be amended by adding the following after the period in line 13: "Such report shall include a record of consultations with all advisory councils, recommendations of all advisory councils and comments thereon."; that section 702, subsection (a), paragraph (2), page 15, be amended by adding the following after the word "purposes" in line 5: "and the

State agency shall take cognizance of and be guided by the advice of the State Advisory Council,"; and that section 712, subsection (a), paragraph (2), page 17, be amended by deleting the semicolon in line 22 and substituting a period to be followed by the sentence, "The State agency shall take cognizance of and be guided by the advice of the Advisory Council."

III. *"Provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State Government. Part of the burden of this responsibility may be assumed by charitable agencies. Federal grants-in-aid to State programs administered by State boards of health are an acceptable method of helping to meet this responsibility"*

S. 545 provides that on or before 1949 the State administrative agency shall be the State health agency. In Massachusetts the relationship between the State health department and the medical society is eminently satisfactory. It is conceivable, however, that in certain States the medical profession might not have an authoritative voice in the formulation of policies and plans of the State health department and that under such circumstances the term "low income" might be so interpreted as to make essentially the entire population eligible for benefits. It is therefore recommended that the term "low income" be clarified as to its meaning and intent.

IV. *"The medical care of those who are able to purchase it by voluntary prepayment plans or by direct payment is the responsibility of the individual"*

S. 545 states that it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status. Actually the bill provides for the establishment of plans for families and individuals of low income. As previously stated, there is nothing in S. 545 that would prohibit a State from applying the term "low income" to substantially its entire population except the limitation placed on available funds in section 77, page 16, lines 20–22. It is therefore again recommended that the term "low income" be defined.

V. *"Eligibility for receiving benefits under a program aided by Federal grants should be determined by the individual States"*

S. 545 states that no plan or modification shall be disapproved by the Director of the Office of Medical and Hospital Care Services because the Director disapproves of the methods proposed. It also states that it is intended that the State shall devise in each case the methods by which this plan shall operate.

VI. *"The patient shall have free choice of his physician, group of physicians, clinic or hospital from among those participating in any plan, provided that the physician, group or physicians, clinic or hospital selected shall have the right to refuse to accept the patient"*

Nothing in S. 545 as it is written is inconsistent with this principle.

VII. *"Physicians and other qualified persons rendering medical care should receive adequate remuneration for their services"*

S. 545 leaves the amount to be paid physicians up to the States and presumably the fees would be adequate though minimal.

Out of the annual appropriation of $200,000,000, Massachusetts might receive $5,166,400. To this the Commonwealth would be compelled to add at least a like sum, giving a total of over $10,000,000. At the present time this amount would be sufficient to insure 200,000 families in Massachusetts' voluntary medical- and hospital-care plans. It therefore might seem to approach an adequate amount with which to inaugurate the program in Massachusetts on a prepayment basis or otherwise.

VIII. *"The physician shall be free to elect or reject without prejudice participation in a medical-care plan. The rights of the physician as to the choice of methods by which he is to be paid shall be fully protected"*

S. 545 leaves the method of selecting and paying physicians to the States. Aside from the State advisory committee, which actually has no real designated powers, there is nothing to prevent the formulators of the State plan from establishing such methods of choosing and paying physicians as strikes their fancy: It is to be anticipated, however, that a program as important as this one would be worked out on a rational basis.

In addition to the foregoing recommendations the following are also submitted:

That section 102, subsection (b), paragraph (4), page 4, shall be deleted, and that the following shall be substituted, "make reports and recommendations with respect to the most efficient policies and methods for promoting the designated functions of the Agency".

That section 104, subsection (c), page 9, be amended by striking out the words "who has had at least five years of active medical practice and", in lines 15 and 16.

That section 104, subsection (d), page 10, be amended by striking out the words "Surgeon General", in line 11, and by substituting the word "Administrator".

That section 712 be amended to include a subsection (c), on page 21, which shall state, "If any State is dissatisfied with the Council's action under subsection (b), such State may appeal to the United States circuit court of appeals for the circuit in which the State is located."

That section 714, subsection (b), page 24, be amended by deleting the words "Surgeon General" from line 11, and substituting the word "Director".

We would like to emphasize the desirability of gradual evolutionary rate of expansion of plans for distribution of medical care. We think we are following logical lines in our own State. There will always be the group of medical indigents who are not able to meet the costs of major diagnostic problems or catastrophic illnesses. Perhaps the average family meets these situations only once in 6 years. These people at present are subsidized by the doctors and the hospitals.

I would like to quote from the conclusions of the State advisory council, Division of Unemployment Security of Massachusetts, presented after long and careful study, to the 1945 session of our legislature:

"While the council senses a strong desire for an extension of facilities to aid in meeting the costs of unusual or prolonged illness it is not convinced of any pressing need or urgency for governmental compulsion in the Commonwealth of Massachusetts to accomplish it at this time in view of the growth and trend of development along voluntary lines.

"It was found on a spot check of the working population covered under the unemployment-compensation law, which represents approximately 75 percent of the total working population in the Commonwealth, that 65.9 percent or nearly two-thirds (it is over 71 percent now) of the individuals were covered in their places of employment by some form of voluntary protection against loss of wages due to illness.

* * * * * * *

"The present voluntary coverage in health and accident protection in Massachusetts, including cash payments for wage loss, is striking evidence of a consciousness on the part of employers, trade unions, private insurance carriers, and the medical profession for the 'social security' of the people of Massachusetts and of what can be accomplished through coordinated efforts in the private-enterprise system. The plans in existence cover this protection to a previously unbelievable extent. Most remarkable, also, is the extent to which the citizens have availed themselves of the opportunities afforded by the various individual and group plans. The council would question the advisability of disturbing or perhaps thwarting the gains thus made, as the economic independence thus attained when the people meet these problems themselves is democracy in action.

"It may be questioned, for example—

* * * * * * *

"3. Whether anything but a major hazard should be provided for by governmental compulsion;

"4. Whether governmental compulsion is necessary until such time as it is clearly demonstrated that private enterprise cannot assume the responsibility;

"5. Whether the role of Government should not be one of adding impetus to the establishment and expansion of private plans rather than in direct participation."

In conclusion I would like to quote from an editorial in the New England Journal of Medicine on May 1, 1947.

"S. 545 seems to be, at least so far, the best framework on which to build the kind of health legislation that the country needs. It is to be hoped that, after conflicting groups have made the necessary compromises that are a proper mechanism for foregoing laws in a democracy, the foundation of a broad progressive system of medical care will be evolved."

## Supplementary Statement of Dr. Charles G. Hayden, Medical Director of Massachusetts Medical Service and Massachusetts Hospital Service, Inc.

In Massachusetts we have a voluntary hospital-care plan and a voluntary medical-care plan. Massachusetts Hospital Service, Inc. (Blue Cross), covers approximately 2,000,000 persons—about one-half the population of the Commonwealth. Massachusetts Medical Service (Blue Shield), a much younger organization, covers 600,000 persons, and its rate of enrollment is increasing rapidly.

As of June 1, 1947, Blue Cross, which offers a semiprivate contract and a ward contract with a family income limit of $2,500, extended its program to cover all services customarily furnished and billed by the hospital during a period of 120 days per admission. At the same time, Blue Shield extended its program of benefits for surgical and obstetrical services rendered in the hospital to include benefits for medical services rendered in the hospital and for surgical and obstetrical services rendered outside the hospital.

The Massachusetts Blue Cross plan, in organization and operation, is similar to most other large Blue Cross plans. While the Blue Shield plan is likewise similar in many respects to other large Blue Shield plans, it has characteristics with which the committee may not be familiar.

The affairs of the Massachusetts Blue Shield are directed by a board made up of one-third physicians and two-thirds laymen. At the present time representation is as follows:

Internist.
Roentgenologist.
General surgeon.
General surgeon.
General practitioner.
Personnel manager.
Personnel manager.
CIO representative.
AFL representative.
Department of labor and industry representative.
Banker.
Industrialist.
Industrialist.
Industrialist.
Hospital administrator.

Although changes in rules and regulations affecting medical matters must be formally initiated by the physicians on the board, who constitute a central professional-service committee, the lay members customarily discuss such matters and related motions have always been subjected to action by the entire board.

Under the Blue Shield Enabling Act, the commissioner of insurance must approve in writing all subscription agreements, participating-physician agreements, subscription rates, and schedules of fees. He may also limit acquisition and administration costs and require that a special contingent surplus be accumulated and maintained. Inasmuch as the commissioner represents all the people of the Commonwealth, and because the Blue Shield board of directors is made up of two-thirds laymen, it would seem that subscriber interests are well protected.

When Blue Shield was established, two categories of subscribing members were designated—unlimited (under income) and limited (over income). An unlimited member was any subscriber without member dependents whose annual income was $2,000 or less or any one of a family group the total annual income of which was $2,500 or less. A limited member was one whose annual income exceeded these respective amounts.

For such services as are listed in the subscriber's certificate, the unlimited member is subject to no additional charge over and above the Blue Shield fee-schedule allowance. The limited member, however, is subject to an additional charge privately agreed upon by the patient and physician.

According to statistics furnished by the Massachusetts Department of Labor and Industry, the original Blue Shield income limits blanketed 80 percent of the wage-earning population into the unlimited (under income) category—where they were eligible for service benefits without additional charge. Because of increased wages during and following World War II, this percentage dropped to about 65 percent. Consequently, the council of Massachusetts Medical Society, after studying the problem, voted to increase the limit for the family to $3,000, thus restoring the original relationship. Inflation affects physicians as well as patients, yet the Massachusetts Medical Society voted to increase the income limit for the family without asking for a compensatory increase in the Blue Shield schedule of fees, in which, incidentally, an appendectomy is listed at only $75.

Prior to June 1, 1947, Blue Shield enrolled subscribers on a group basis only. Subsequent to that date, enrollment policy was extended to include two additional methods—community enrollment and physical examination enrollment.

Any individual or family not associated with an eligible group may enroll in Blue Shield during community campaigns which are now being scheduled in nearly 100 Massachusetts cities and towns each year. Benefits under this type of enrollment are the same as under group enrollment.

Any individual or family not associated with an eligible group who, for one reason or another, does not enroll through community enrollment may join at any time through physical examination enrollment. On the basis of a physical examination, the applicant is accepted with a waiver on known conditions likely to require treatment, or rejected. Because persons accepted with a waiver or rejected may subsequently enroll during a community campaign, physical examination enrollment is a stopgap device which will ultimately abolish itself.

More than 90 percent of the physicians in Massachusetts are participating, under contract, in Blue Shield. They are doing so not because they fear compulsory governmental health insurance, but because they individually and collectively recognize a fundamental social and moral obligation to provide the people of Massachusetts with the best possible medical care on a basis commensurate with their economic abilities.

Blue Shield has long been coznizant of the fact that there is a certain segment of the population which it can never reach unaided, consequently a supplement such as is embodied in S. 545 is necessary to complete the medical-care picture in Massachusetts.

## STATEMENT OF ERNEST R. GEDDES, MEMBER OF THE ASSEMBLY, CALIFORNIA STATE LEGISLATURE

Mr. GEDDES. My name is Ernest R. Geddes, member of the assembly, California State Legislature.

Senator SMITH. I want to express my personal appreciation for Mr. Geddes' willingness to come here and give us the benefit of his California experience, especially from the standpoint of his being in the legislature there and his looking at the problem from that standpoint.

Would you give us a brief statement of your background and your interest in this subject?

Mr. GEDDES. I will, and I may say I represent no one, although I am in the legislature representing the Forty-ninth District, Assembly District, of California and, to the best of my ability, the people of that State in State-wide problems.

My interest in this measure is explained in the introduction to my brief; but as an additional statement, let me say that this is a subject that, when we get into it, we realize its importance.

As will be explained, I did some work and had some considerable experience directing the affairs of an interim committee set up to study this problem. I have not ceased studying it and I am very much interested in S. 545. I believe the remarks and data I furnish may be of interest to this committee.

Senator SMITH. Mr. Geddes, I have a volume here entitled "Final Report of the Assembly Health Care Investigating Interim Committee," House Resolution No. 295. I assume that is the California Legislature?

Mr. GEDDES. That is right.

Senator SMITH. It is dated July 1, 1946, and it lists, among others, Ernest R. Geddes, chairman. You are that Ernest R. Geddes?

Mr. GEDDES. Yes.

Senator SMITH. I just wanted to identify you as part of the organization.

Mr. GEDDES. And I may add, sir, that in the brief I have incorporated in this volume, which I furnished to all members of the committee, as part of the record by reference because it contains statistical material which may be of value to you.

Senator MURRAY. Before you start, I would like to inquire if you have had an opportunity to examine the new compulsory health bill which has been filed as S. 1320?

Mr. GEDDES. I only received a copy last night. I was visiting Congressman Nixon and he procured a copy for me, and I have received S. 545 and I directed my remarks directly to that, sir.

Senator MURRAY. I was going to say, I would be willing to furnish you several copies and also an abstract of it and the statement made in connection with it so you would have an opportunity to study it and I think if you do go over it carefully, you will find that it overcomes the objections that were heretofore lodged against it and that it now is in much better shape than it was.

Mr. GEDDES. I will read it with considerable interest.

Now, for the purpose of the record, I am not a doctor but an advertising man who happened to get into the legislature.

During the fifty-sixth session of the California State Legislature two bills were introduced in the assembly providing for systems of prepaid health insurance. Both were compulsory as to the requiring of contributions based on a percentage of wages from employees in subject employment to be matched by equal contributions from the employer.

Companion bills were introduced in the Senate. However, hearings on the two assembly bills, numbers 800 and 447, were the only ones conducted. Hearings were held in various California cities during the Constitutional recess in February 1945 and were continued in Sacramento, the State Capitol, when the legislature reconvened.

Assembly bill 800, sponsored by Governor Earl Warren, would have remunerated the physician on a "fee for service" basis. It provided that administrative expenses be borne by the fund fed by the employee and employer contributions.

Assembly bill 447, known as the people's health act and sponsored by the CIO, provided for physician payment on a capitation basis. The State was to provide care for indigents insofar as their contributions to the fund would be paid by the State. Administrative costs of the system were to be paid for by an appropriation from the State's general fund.

Most of the testimony presented to the standing committee of the assembly on public health dealt with the principles involved in a compulsory system. Since there was little discussion comparing the two bills, it is safe to assume that the proponents of either measure would have readily accepted either of the two bills. The opponents were adamantly opposed to both.

Senator SMITH. Let me ask you, you say both these bills provide compulsory insurance?

Mr. GEDDES. That is right, and the people want them so badly that the backers of one bill would have gladly accepted the other, I believe.

Neither of the two bills was reported out of committee. Efforts to withdraw them from committee failed—but not before the entire issue was thoroughly debated before the entire membership of the lower house.

We went into Committee of the Whole to determine whether we would withdraw the bills from the committee.

While the proposed legislation failed of enactment, much interest was generated and it was felt that some of the most important questions were left unanswered. Accordingly, a special interim investigating committee was created by the assembly to study and ascertain the facts relative to health care for the people of California.

Senator SMITH. Was that the committee of which you were chairman?

Mr. GEDDES. That is right, sir.

The committee consisted of Assemblymen Sam L. Collins, now speaker; James G. Crichton; Ernest E. Debs; John W. Evans; Fred H. Kraft, now in the California Senate; Vincent Thomas, author of the CIO bill; and myself.

I was designated as the chairman of the committee for two principal reasons. First, I had evidenced a disposition to study the matter factually and objectively and in a spirit of neutrality. Secondly, I was neither the author of the resolution nor a member of the committee which had before it the two previous measures.

Senator MURRAY. Sponsored by the CIO.

Mr. GEDDES. That is right.

Vincent Thomas, one of the members of the committee, was the principal author of that.

Senator MURRAY. And neither one of the bills was reported?

Mr. GEDDES. Neither one reported out of committee.

Let me say that as a businessman I took a little different view of the legislative interim committee and we returned at the beginning of the session about $23,000 out of $50,000, because we made no junket tours and we felt that where a 3-cent stamp would serve the purpose, that was sufficient.

Senator SMITH. What chance have you of coming to Congress?

Mr. GEDDES. I do not know; we will have to ask the people some day. [Laughter.]

As I mentioned, an appropriation of $50,000 was made to conduct our studies. We were to bring in our final report by July 1, 1946.

After our first hearing, the members agreed that the sociological and political arguments presented were but a repetition of arguments for and against compulsory sickness insurance. These had been presented many times and in many places in the past.

It was therefore agreed that if a substantial service was to be rendered to the legislature, we should go after factual information.

We therefore set out to make an actuarial survey of all the data obtainable in order to determine—

1. The incidence of illness and hospitalization which might be expected to obtain in large population groups; and
2. A valid estimate of possible costs of rendering medical and hospital service.

To further these objectives the committee then rented suitable headquarters, employed a staff, and secured the services of Virgil M. Griffin as actuary on a full-time basis. I acted as coordinator for the committee and personally put in over 1,000 hours of study and research.

Senator MURRAY. I would like to inquire: Have some lay studies been conducted in other parts of the country?

Mr. GEDDES. I do not know of my own knowledge. Different studies have been made and, of course, the California Senate in 1935 had conducted quite a comprehensive survey, but it was based more on the ability of different groups to pay their medical costs.

Senator MURRAY. I would be interested to know that other studies have been made in other parts of the United States and what their report would be.

Mr. GEDDES. It is because of the knowledge gained in considering the many problems, and because your committee is studying similar problems, that I have accepted your invitation to appear before you here today.

Having read S. 545 I recognize that it is the intent of the authors to present a plan to meet the health needs of a portion of the population in the several States through a program which will make unnecessary compulsory sickness insurance. I believe that is the chief distinction in the bills before you. Also, in section 2, subsection (d), you are providing for a health program for Federal employees voluntary as to salary deductions paid to voluntary nonprofit health insurance funds. And may I say that I recognize that there is some considerable interest. We have it with the State employees of California, also.

Since the scope of your subject is so great and since your decisions will be so vital to the welfare of all, I shall present only such agruments as may be substantiated by reason and proof.

For the most part, the statistics I will use are from the final report of our committee. It is being made a part of this report by reference. Copies have been supplied to all members. When reference is made to other sources it is so indicated. Pertinent tables appear as an addendum to this brief.

With this introduction, gentlemen, I wish to present for your consideration the following statements:

There is considerable confusion in the public mind as between health insurance and health service.

The real principle of insurance is to provide for indemnification against the costs of hazards which are possible or probable as to their occurrence but are not certain. They occur with such relative infrequency that a comparatively low premium may be reasonably expected to provide ample protection under the definite provisions of the policy. The policy is the contract between the insurer and the insured.

Prepaid health insurance or sickness insurance, to use a better definition, is practicable when it is safeguarded by limitations of the hazards insured against.

Policies thus limited in scope touch only the high costs of medical care. Consequently, there is left in the public mind a desire for policies containing fewer limitations or exclusions. What is meant, therefore, by health insurance is really health service entitling beneficiaries to receive medical care and hospitalization because of the prepayment of supposedly averaged costs of a given section of the population.

Senator SMITH. Mr. Geddes, you heard Dr. Hayden testify just now with regard to Blue Cross on one hand and Blue Shield on the other?

Mr. GEDDES. Blue Shield, as I understand it—and we have the same situation in California—is an attempt to do just what I have stated: to go past the strictly hospital provisions of a hospital insurance which could be sold at relatively low cost. But to provide for ample service—and I believe that the insurance companies and the physicians are getting into, we might say, a competitive spiral—competition to meet the demands of the public and the desire of the public to have something as nearly complete as is possible.

Senator SMITH. You think, then, that the Blue Shield movement is an expanding service given for premium?

Mr. GEDDES. I think that it is, sir.

The many voluntary plans, both nonprofit and commercial, have recognized this demand. They have extended the coverage of their policies with, of course, a corresponding increase in the premium or contribution charged.

This has led the proponents of compulsory plans to claim that existing voluntary plans are inadequate, and we have that claim in California and I think probably the testimony of the beneficiaries would substantiate that: that they are either too costly for families in moderate circumstances, or that benefits from the low-cost plans are too limited in scope to provide the comprehensive service desired. Since S. 545 is an answer to this claim and a solution to the admitted problem, I invite this committee to test this argument and I believe your conclusion must be that this is the crux of the matter.

The very costs which act to increase the premium under comprehensive voluntary plans must continue to exist under compulsory or Government-operated plans unless—

> Hospital costs are reduced;
>
> Physicians' fees are reduced under a "fee for service" schedule; or
>
> Physicians are paid on a capitation or salary basis;
>
> Means are found to render medical, hospital, and surgical services on a production basis at endowed or State-supported hospitals and clinics, with physicians paid on a salary basis or donating their services.

What I mean by that is that if we are taking costs, the cost of operating a plan and paying those who render the services, certainly you cannot bring costs down without finding a way either to pay less or to get a more efficient or a different method of administration for the service. That would be applicable to any plan; it makes no difference. And in California they do not want some—we have very good county hospitals and some poor county hospitals. Just back-tracking a little, the last solution—the capitation one—is merely an amplification of the present county hospital system. While perhaps desirable to afford medical services for those in the lowest income brackets, it is, in my opinion, unacceptable to the average citizen. He envisions a plan whereby he may walk into the office of the physician of his choice, select his own hospital with the feeling that he is receiving the best care there is to be had, and that he is well on his way to recovery.

The second point I want to make is that it does not necessarily follow that to broaden the base of coverage reduces the cost of care provided by insurance. The continued use of this second argument, even by persons in high places, indicates widespread misinformation or misunderstanding of most fundamental principles. This is easily illustrated.

The research of our committee—and I may say that it is backed up by the committee on the cost of medical care and others—showed that the incidence of illness during 1 year is equal to or in excess of 600 cases in every thousand of population as a whole. Other studies, including those of the proponents of compulsory health insurance, agree on this figure.

Most of the confusion regarding this subject is brought about by producing tables and charts involving millions and billions of dollars.

For the sake of better understanding, it is my belief that the entire matter may be more readily analyzed with a smaller unit. Let us, therefore, estimate the amount of contribution necessary to provide just $1 worth of care to each claimant.

As previously stated, in any group of 1,000 persons, populationwise, we can reasonably expect 600 illnesses or claims per year.

To provide $1 of benefits to each claimant, then, will require 60 cents of contribution from every insured member whether they make that contribution themselves or not.

Whether this group is 100 persons or 10,000 or 1,000,000, the ratio remains the same. Widening the base, of the number insured, does not lessen the cost per insured person of furnishing the promised services to the persons who will suffer illness or accident and claim such services.

With this in mind, we cannot escape this conclusion to wit: that the proposed solution is that each dollar of benefits must purchase more services. And this can be done only by one of the following ways:

1. Paying less to those who render the service; or
2. Discovering production methods of medical care; or
3. Trying to wholeseale medical practice. This, of course, would eliminate the personal and confidential relationship between physician and patient as it now exists.

Point No. 3—and this is in respect to S. 545—pertains to payment by the State, in the nature of premiums, partial premiums, or reimbursements of expenses to voluntary nonprofit health, medical, or hospital insurance funds would lower the costs of premiums or contributions to the insured while assuring physicians and hospitals of adequate remuneration for their services.

This seems to me to be a way by which the necessarily high cost of health insurance may be reduced, thus making it more readily available to families of low income.

It is diametrically opposed to former proposals made by proponents of compulsory health insurance whereby the amount of the premium would be set at a percentage of the insured's wages or income. In all such proposals the amount of the contribution required to be paid has been lowered as to the individual by provision that the employer pay a proportionate amount.

It can also be demonstrated that if the coverage is extended to include those in the higher-income brackets, it is possible that the contributions required may amount to more than the average cost of medical care for all incomes.

Such a plan would also allow the setting of basic premiums for men, women, and children rather than a flat premium based on the income of an individual and insuring him and his dependents regardless of the number of such dependents.

Our chief difficulty in California in making our surveys was to find valid experience as to costs where unspecified numbers of persons in the family were insured, and it is my opinion that it is sound insurance practice to set a premium for each person insured.

The chief objection to this practice is that if the amount of the premium is high, there is a tendency to insure only those members of the family who are poor risks.

I may say that the early experience of the San Francisco plan for municipal and county employees demonstrated that. When the plan was threatened with insolvency they had Mr. Nelson, an outside actuary, come in and analyze the plan. He reported that they could not raise the cost for children or for retired members without creating feeling against the plan because only those who are likely to use it would insure at a higher cost while those who were more liable or likely to remain—well, they would avoid the extra expenses and stay out of it.

The payment by the State in such cases of premiums or partial premiums could be used to establish rates on a sliding scale and so low as to encourage the head of every family to insure every member in it.

Another way in which participation by the State can be expected to afford protection to a greater part of the population is that the payment by the State could be used to offset the increased cost of writing individual policies. Most voluntary nonprofit plans as well as the commercial plans restrict most of their coverage to groups. This practice is not only to avoid the dangers of selection against the plan, but also to reduce the costs of collecting the monthly, quarterly, or yearly premiums.

This practice is carried over into proposals for compulsory plans whereby the employer collects the contributions as in unemployment insurance.

When the legislation mentioned earlier was before us in California every member of the assembly received many communications from the self-employed, farmers and retired people of low income, asking why they were left out and an attempt was being made to provide insurance only for those on a pay roll.

The people of California are waiting for a solution of the problem of providing against the costs of medical care, surgery, and hospitalization. In increasing thousands they are subscribing to the voluntary and commercial plans—but for many the costs are too high.

Encouragement of private initiative to do the job will, I believe, take care of all classes of people.

Building of hospitals so that there will be beds for those who need them—and may I say right here that in California we need today 18,000 beds in our private hospitals, not Government hospitals but in private hospitals—the establishing of clinic and treatment centers in areas where none or too few exist, the providing of dental care for school children and, last but not least, the promotion of maternal, prenatal, and child care are projects in which the Federal Government will find us cooperative.

I also note the provisions in S. 545 for the collection and analysis of statistics and the making of studies and investigations.

As I said at the beginning it is in the making of such studies that I am particularly interested, and will be glad to answer in the balance of the time allowed me any questions you may care to ask concerning the researches made by our committee.

That, gentlemen, concludes what I had prepared. There is an addendum to my statement which goes on. I have here pertinent data collected from the reports of the committee in arriving at the cost of furnishing medical care. If you would like me to continue, and you interrupt me at any time, I will be very glad to do so.

Senator SMITH. I would like to interrupt you for a minute.

Last night I was looking over your report here that you referred to earlier, the final report of the Assembly Health Care Investigating Interim Committee dated July 1, 1946, and I was interested in some of the comments you made there, especially on page 30 at the very bottom of that page where you use this language:

> Summing up the above: The majority of the committee agree that there is a conflict not only of opinions and interests but also that there are fundamental objections to compulsory insurance, not on the ground that a large portion of the population does not require more and better medical care but that compulsory insurance will not necessarily provide it without introducing new problems and, perhaps creating evils of no mean magnitude.

Is that your own conclusion as well as the majority of the committee?

Mr. GEDDES. That is my conclusion, sir, and I might qualify it in this way: I am not particularly interested in whether compulsory health insurance is socialistic or not. I will have to go to the record and find that very fine men, our own Governor Warren and Theodore Roosevelt as well as President Franklin Roosevelt, President Truman and others who are not socialistic have advocated some plans and recognized the need.

My thought in subscribing to that statement by the majority of opinion is that the evils of no mean magnitude might be a lessening of the real interest and desire for proper growth on the part of the medical profession and it is the present members of the medical profession to whom we must look should any plan be established and made to work. They are the people, whether we throw bricks at them or not, we would ask to come in and render services.

As to the other side of the problem, as to whether the State should grasp the nettle and go in and put in State clinics operated at Government expense or State expense, so that all people if they could not get service in any other way—I say it is something that perhaps in our evolution we could go for, particularly in the areas where private enterprise has been unwilling to go in and establish such treatment centers.

Now, the evils that could occur, to my mind, are these: First of all, in California if every person had been insured, if the two bills previously mentioned—if either one of those had passed, today people would have paid contributions for a year; they would be entitled to the service by the terms of the bill and if they would walk into these hospitals and say, "Here is my card, I am paid up, I want service"—

we just have not got the beds to put them in and at the time that was written we did not have the physicians in California, so that a person having by virtue of having paid his premium would be entitled to the service and go up to the State that guaranteed the plan as the chief insurer and was responsible for it, could not deliver. We would not allow private enterprise to make that kind of a contract with people.

Senator SMITH. The suggestion has been made, Mr. Geddes, that the deduction from pay roll is not payment for premium; it is a form of tax which the Government takes to render a service.

Now, you have just suggested that a person may show he has had deductions made from pay roll and that he is entitled to certain coverage of service. Then he goes in and cannot get the service. That suggestion has been made by others. To do a job such as the over-all compulsory health insurance bill appears to call for, it might take a generation to put in into effect in order to give it value.

Is that your feeling?

Mr. GEDDES. That could well be, but I feel that if a person has something which entitles him to medical care, and we are continually talking about a system of health insurance, that regardless of whether we call it a tax or a contribution or payment of premium where the principal remains the same, the person is by virtue of his economics entitled to the benefit.

Senator SMITH. He has paid for something. I agree with you. Regardless of what you call it, he has made his payment and expects to get benefits. And at the same time we have heard that we are not organized yet to render that service that the person pays for.

Mr. GEDDES. That is right.

Senator SMITH. Now, then, would you say in California from your contact with figures there that generally they were opposed to the compulsory insurance plan or were they in favor of it? From one angle it would look as though it would help them because it means they could raise the fees.

Mr. GEDDES. They collect fees and they have their voluntary plans and I have no quarrel with the physicians in California and yet I'm not carrying the torch for them, either.

I believe, though, that we will find this is true, that all of us, or most of us resent compulsion. When we were discussing making the survey of public opinion we had long discussions among ourselves as to whether or not we dare use the words "compulsory system," because we thought the term might be supplanted and there is no synonym for exactly what we mean.

Senator MURRAY. Of course we all resent compulsion. I remember when I started to go to school I resented the idea that I was compelled to go.

Senator SMITH. Probably as we mature, Senator Murray, we even resent compulsion more.

Senator MURRAY. At this point you were talking about the attitude of the medical profession there with reference to compulsory system of health insurance. What is the attitude of the people generally in your State?

Mr. GEDDES. Well, the people want something. They are willing to have a State plan, as far as the public-opinion survey that we did take finally went, but they do not particularly fall for a compulsory idea.

Senator Murray. I have a memorandum here to the effect that the public-opinion poll was taken of the people of your State by a reputable firm and for the California Medical Association. Even though they used the words "socialized, government-control plan," 50 percent of the people of the State voted for it. Are you familiar with that?

Mr. Geddes. I heard that survey mentioned in one of the hearings which I attended. However, the surveys which we made would show that that factor is about correct, as I remember it. We made a survey of our own, not wishing to take another survey which was challenged by one party or the other, and you will find our surveys and the results from it, including a chart of fees and additional charges and eligibility of various types of healers, and the acceptance of a plan and desire for a plan all covered in the last pages of the book. I think that will answer your question.

Senator Murray. Now, I understand that the American Federation of Labor and the CIO in your State represent a very large section of the population strongly favoring the compulsory health-insurance plan.

Mr. Geddes. They came out for it, particularly in senate bill 447; that was backed by the CIO.

I think what might bring it up to date, that session, at the present session an attempt was made to introduce legislation to provide a compulsory health-insurance plan which would touch not only the catastrophic incidents, and in spite of all the heat generated at the previous session, the two bills that were before us, both in the assembly and in the senate, received very little support at this time—I think bearing out what I said previously that people want a complete health service rather than——

Senator Murray. Is there another committee of the senate in California carrying out investigations?

Mr. Geddes. Yes; the senate appointed a committee at the same time as the committee which I headed was appointed and they had until this January to report. They have made their report and they were the ones that endorsed a modified plan requiring contributions, and, as was more or less categorically stated in this report, that a system such as was contemplated in the legislation previously before us could not be provided for 3 percent of the pay roll, they undertook to see what could be provided, so analyzing the provisions of those bills you will find those tabulations on pages 8 and 9. They come to the point where it would take collections made up of about $5,000 of income at a higher rate to provide a full scale of services.

Senator Murray. Now I understand that this other senate committee of yours recommended in part that the State of California should establish a complete system of health insurance at once.

Mr. Geddes. That is right. That was in the report of the committee.

Senator Murray. I understand also that your Governor, Governor Warren, has stated his conviction that compulsory health insurance is wanted and needed by the people of your great State.

Mr. Geddes. That was the Governor's statement.

Senator MURRAY. In 1947 he had caused compulsory health insurance bills to be introduced in the State of California's Legislature.

Mr. GEDDES. That is correct, sir.

As I started to say a minute ago, notwithstanding his support of the measure the bill introduced based on the current senate committee's report failed to come out of the committee and it has yet to be heard on the assembly side.

Senator MURRAY. We have no representatives here from California representing the viewpoint of the Governor of the State or the viewpoint of these other organizations such as the CIO and A. F. of L.

Mr. GEDDES. That is right. As I say, I am speaking only as an individual.

Senator MURRAY. You do not represent any organization.

Mr. GEDDES. No, sir.

Senator MURRAY. It would seem to me that in view of the division of opinion there and the fact that studies should be made on both sides of this subject that it would be well if we had representatives from the State of California who would speak from the standpoint of the other side.

Mr. GEDDES. I am sure that you would find some who would be very glad to testify representing those other parties. I will say, Senator, that I have here only a single copy, but I will file it with the committee. It is a copy of the Daily Journal of the senate calendar for the current session, issue of January 15, and it contains the report of the senate committee and I will be very glad to leave this single copy with the committee for your use. It is not published as a single document so I could not bring additional copies but I will be very glad when we are through to leave it.

Senator SMITH. You may file it with the committee.

Senator MURRAY. I would like to file at this point a statement verifying the questions I have just presented with reference to the situation in California and also a clipping from the San Francisco News of May 22, 1947.

Senator SMITH. It may be received.

(The material referred to is as follows:)

### "COMPULSORY" HEALTH PLAN WINS BLESSING—MEDICAL, HOSPITAL LOBBYISTS BACK NEW ASSEMBLY BILL

(By Mary Ellen Leary)

SACRAMENTO, May 21.—The medical profession's "compulsory" health-insurance bill—quite different from defeated proposals by Gov. Earl Warren—sailed out of public health committee to the assembly floor today, with a 9 to 1 vote and the blessing of medical and hospital lobbyists.

This measure is wholly concerned with private group insurance taken out by employers for their workers with the workers' own money. It also regulates doctors practicing as a group.

#### ANOTHER PROTEST

It was attacked by labor representatives and some insurance concerns as "compulsory." Charles Scully, AFL spokesman, said it permits employers to contract for medical, surgical, or hospital prepayment plans, then go ahead and deduct part of a worker's wage to pay the premium, without getting the worker's consent or even warning him the deduction was coming.

"This indicates the doctors are in favor of compulsion, provided they do the compelling," he said.

John V. Hines, executive secretary of the State Association of Life Underwriters, protested this same "compulsion" on the basis that insurance companies "always wanted group plans to be voluntary."

### PROVISION CITED

The State insurance commissioner, through his deputy, Frank Fullenwider, also objected saying laws already regulate disability insurance thoroughly, and this would interfere. This bill lets the State board of public health O. K. doctors' group or association operations.

Doctors, practicing as a group, must show their plans do not interfere "with good medical practice" or "do not operate in such a manner as to interfere with reasonable competition among physicians and surgeons in the community," the bill provides.

The bill also provides that a worker shall not be covered by the private medical care insurance on any sickness or injury for which State workmen's compensation is provided.

A section which would prohibit employers from acting as agents for any such medical or hospital plan was deleted. Also cut out of the bill, before it passed, were original statements that it would apply only to nonprofit plans.

Assemblyman William Rosenthal (Democrat, Los Angeles) was the only committee member voting against the bill. All others approved it, including Assemblyman Ray Blosser (Republican, San Francisco), John F. Thompson (Republican, San Jose) and Richard McCollister (Republican, Mill Valley). Mr. McCollister authored it, along with Speaker Sam L. Collins, and several other Collins' lieutenants, including Randall Dickey (Republican, Alameda) and Richard Dolwig (Republican, south San Francisco).

### WARREN COMMENTS

Governor Warren, meanwhile, in a press conference, yesterday, commented on the section in the proposed Truman health insurance plan that would settle major responsibility on a State level.

"To me," he said, "it is as certain that we are going to have a health insurance program for our people as I am sure the sun will set this evening."

He warned against grabbing for it, however, as hasty legislation in a time of depression.

"I don't think it is undesirable to have a Federal interest," he said. "But if the States try to do the job, establish their virility in these fields, even though they may get some Federal assistance later, they have preserved the substance and spirit of democracy longer. Local governments must assume responsibility instead of delegating it all to Washington."

Senator SMITH. I would like to ask just a question or two to supplement your testimony. I notice on page 6 of your testimony under the heading of Addendum, you use this language:

> In our report to the legislature, in the summary of the findings of the committee, it is stated: "Compulsory sickness insurance cannot be provided for 3 percent of pay roll unless—
>
> "(*a*) Physicians operate on a salary, capitation, or reduced-fee basis; or
>
> "(*b*) Medical care is rendered through group practice with facilities provided by the State; and
>
> "(*c*) Hospitals are supported or regulated by the State or new methods of hospitalization as relating to operative and nonoperative cases are adopted; or
>
> "(*d*) Indigent sick are still cared for as at present."

In other words, your conclusion would be that the 3 percent payroll deduction would not take care of the cost of a program for the State of California unless these other provisions applied.

Mr. GEDDES. Then I qualified that by the immediately following:

Senator SMITH (reading):

> It would seem that our statement as to the alternates should have included provisions similar to those expressed in S. 545, but the point I wish to bring out here is that an investigating committee of the California Senate operating independently of the assembly committee brought in a report on January 15,

1947, in which carefully worked out computations bear out what some have considered as a categorical statement by our committee.

Mr. GEDDES. That you will find in this copy as well. I have reproduced the two pertinent tables which you will find here on pages 8 and 9.

Senator MURRAY. Could you send the committee other copies?

Mr. GEDDES. I will see if there are sufficient still in print, Senator, and I would be very happy to send them if they are available. I think I can procure perhaps a dozen or so.

Senator MURRAY. A dozen will be plenty.

Senator SMITH. On that last point, your comments on page 7, I might say Dr. Boyes, one of the leading proponents of it is quoted.

It would seem to indicate we have to give up the fee for service principle.

Mr. GEDDES. I think so. Personally, as my own opinion, as I have stated it before I think the CIO proposal was the more honest approach because they were going to take care of certain stated costs first and then divide up what was left on a per capita basis among the physicians and what that would be no one would know.

Now, certainly, if it was going to be low, you would not expect the medical profession or lawyers or anyone else to rush in and take an unknown fee, unknown quantity fee for their remuneration. On the other hand, it was the easiest approach to the problem to say, well, whatever is left of the contribution will be divided, and attempts were made to show that would result on an average as fair income to physicians. But I do not think, based on the insurance standpoint which we are talking about, at least I am, that actuarially it is a sound basis on which to proceed.

Senator SMITH. I would like to make an observation here on your report. This same book, Final Report of the Assembly Health Care Investigating Interim Committee, dated July 1, 1946, of which you were chairman, page 131 apparently gives the results of certain polls that were taken and I just pick out one here with regard to compulsory membership in these plans. The heading on page 131 of this particular poll which was No. 6—

> attitude toward compulsory membership. Do you think that subscription to or membership in a medical or hospital plan should be compulsory or voluntary?

And there are various areas described here where the poll was taken but taking the over-all total, the percentages appeared to be the following: Voluntary, 76 percent; compulsory, 21.7 percent. Is that a correct statement of that poll of the entire State?

Mr. GEDDES. That is a correct statement; the poll was representative. It is my opinion that it is correct. We had no reason to doubt the accuracy of their samples. However, I think it is pretty well qualified by paragraph 7, immediately below:

> There are now available several different types of medical and hospital plans. Do you think the State of California should promote and operate a plan in competition to those in existence?

And you will notice there that 52 percent, or 50.2 percent of the people, said "Yes," upon which I based my statements a few minutes earlier that I believe the people are vitally interested in having an expansion of a health-service plan on an insurance basis that they can afford.

Senator Smith. I think we are all agreed to that. I think that is so not only in California but Nation-wide. We are exploring now what is the most feasible plan.

Let me ask you this: Previously you stated S. 545 had the noncompulsory approach and grants-in-aid permitting the State to develop its own program by trial and error methods. Do you favor that as opposed to the compulsory plan?

Mr. Geddes. I do on a personal basis, from my own individual make-up and the way I see things, and I also believe that it would receive a good deal less opposition and could make the extension of plans which are already growing and started and perhaps bring them into operation in the future a good deal sooner than some of the other more revolutionary plans or evolutionary, whichever way you want to call it, come into fruition.

Senator Smith. Would you agree with Dr. Bagnall's estimate that if we had to have a compulsory State plan it would be wiser to take steps one at a time, a step-by-step procedure in bills such as S. 545 at the present time?

Mr. Geddes. I think, sir, that my statement would be that we are heading toward something, and that is that it is going to take in only those in subemployment.

Now, our large farming communities have been covered pretty well during the last year through contract between the granges and the Blue Cross with medical rider because those people have been left out and had no opportunity before. Also, there are small, retired people who have limited income. They go to California to live and their net income is $100 or $125 a month, which, when they purchased the annuity, looked pretty good, but now is worth only half as much, and they are looking for some way to reduce medical cost and would be inclined toward an insurance plan, and many of them are, but they have to belong to some kind of a group, and most buy commercial insurance which is sold on an individual basis.

Senator Smith. Covered by Blue Cross or Blue Shield.

Mr. Geddes. That is right, but right now, of course, they have to belong to some group to be covered by that and we can understand that. That is one way in which the cost of collections, the cost of operation of the fund can be reduced.

Certainly, the provisions of S. 545 might extend to the point where it would allow these people who are off pay roll to obtain coverage because they get sick and require hospitalization as well as anyone else.

Senator Smith. The compulsory plan or the other principle. Under the compulsory plan it is hard to determine how to reach them.

Mr. Geddes. Problems of cost exist regardless of whether you have compulsory or voluntary.

Senator Murray. I suppose that the economic conditions of the country have a large bearing on this subject of medical care and the kinds of plans that we would have. Following the last World War we went into a very serious depression which made it difficult for large sections of our population to get adequate medical care and hospitalization. Now the world is again threatened by dangerous conditions which may come to us also in this country and the idea of taking care of the health of the people of the country, of protecting it, is a very important matter. It is as important as education and it seems to me that inasmuch as we have a system of compulsory support of education it may be possible to work out a compulsory health insurance system which would be effective and efficient if properly administered. I can see no effective objection to it and I do not think it is fair to call it socialistic or communistic. If it is a good system, we ought to have it and if it is necessary for the protection of the health of the American people, I would not hesitate to support that kind of program.

Mr. GEDDES. As I said previously, Senator, I certainly would not want to quarrel with the terms that are used. As I mentioned, we have some very fine men on both sides of the fence that we are not calling either Fascists or Communists and certainly the problem is this, and I think it is stated in this report, that in a country or a State—take it down at my level, as wealthy as the State of California is, we should not fail to educate our young. No one should die of hunger and people should not die of disease because of being unable to obtain medical care.

Now, how we are going to get that to them at a cost that can be borne at all is something that is very interesting.

You gentlemen of the United States Senate, and the Members of Congress and the people of the State of California only want to consider this on a business-like basis and not fool ourselves and keep everyone as happy as possible and that is the only reason I brought these figures to you because we are all proud of our brain child and I have worked hard and long on this and I felt that I have made a contribution or it can be a contribution to the cause in making some estimates which are valid as to what cost might obtain and then when we find out how to cover those costs and take care of everybody concerned, we have gone a long way down the road to give people what they need and——

Senator MURRAY. How was this poll taken?

Mr. GEDDES. We hired California Associates to make a poll. The committee undertook to set the questions not because we felt that we were brighter than these people, but because there had been considerable criticism of the polling company before where it was pointed out, and I do not think substantiated, that their questions were slanted.

Well, we felt, seven of us, responsible to the legislature that we would determine the questions.

Now it may be that we were not competent enough, but I think the questions will show and the answers made by respondents will show that the facts brought in are at least valid answers from 4,000 or 5,000 people who are a sample of the people in California, for what they are worth, really. Your opinion is as good as mine.

Personally, on a question like this, unless people know exactly what we are talking about, about any suggested plan—I do not know—we can go out and ask them if they are in favor of them.

Senator MURRAY. Slanted questions have a very material effect

Mr. GEDDES. You can make your questionnaire come out pretty nearly any way you wanted if you really slanted them. I assure you I would not testify on it if it were not true. It was not the intent of the committee to slant any questions, but try to get a valid sample.

Senator MURRAY. But my understanding is that the other poll taken in California, while it does contain slightly slanted questions—slanted against compulsory health insurance and referring to it as socialized medicine—the vote was over 50 percent in its favor.

Mr. GEDDES. Brought out the strange contention that this report was rendered—is the middle of the road and because it has arithmetic in it that does not satisfy the violent opponents or the violent proponents, but I do believe it is fair.

Senator SMITH. We are very grateful to you and we will have your entire report that you read sections of to us incorporated in the record, and we will file the report of your committee.

(The report referred to is on file with the committee; the addendum feature of Mr. Geddes' brief referred to follows:)

### ADDENDUM

In what has already been presented in this brief I have stated my own conclusions based on my experience in studying and thoughtful consideration of the subject of health insurance. I believe that they have some bearing on the subject matter contained in measures before the Senate of the United States.

It is hard to condense all the material gained in a year and a half of study into the time and space allowed me, but I now offer for your consideration factual material gained from our own and other studies.

In our report to the legislature[1] in the summary of the findings of the committee it is stated:

"Compulsory sickness insurance cannot be provided for 3 percent of pay roll unless—

"(*a*) Physicians operate on a salary, capitation, or reduced-fee basis; or

"(*b*) Medical care is rendered through group practice, with facilities provided by the State; and

"(*c*) Hosiptals are supported or regulated by the State or new methods of hospitalization as relating to operative and nonoperative cases are adopted; or

"(*d*) Indigent sick are still cared for as at present."

It would seem that our statement as to the alternates should have included provisions similar to those expressed in S. 545; but the point I wish to bring out here is that an investigating committee of the California Senate, operating independently of the assembly committee, brought in a report on January 15, 1947, in which carefully worked-out computations bear out what some have considered as a categorical statement by our committee.

Two tables from the senate committee report[2] referred to are reproduced, as follows:

*Simplified computation[1] of revenue from various tax rates on specified taxable wages in California, 1940, 1944, 1947*

(A) ON BASIS OF 1940 EMPLOYMENT CONDITIONS, WAGES, AND TAXABLE WAGES

| Taxable wages | 3-percent tax | 3½-percent tax | 4-percent tax | 4½-percent tax | 5-percent tax |
|---|---|---|---|---|---|
| $300 [2] to $3,000 | $60,000,000 | $70,000,000 | $80,000,000 | $90,000,000 | $100,000,000 |
| $300 [2] to $4,000 | 63,000,000 | 73,500,000 | 84,000,000 | 94,500,000 | 105,000,000 |
| $300 [2] to $5,000 | 66,000,000 | 77,000,000 | 88,000,000 | 99,000,000 | 110,000,000 |
| (B) ON BASIS OF 1944 EMPLOYMENT CONDITIONS, WAGES, AND TAXABLE WAGES | | | | | |
| $300 [2] to $3,000 | $162,000,000 | $189,000,000 | $216,000,000 | $243,000,000 | $270,000,000 |
| $300 [2] to $4,000 | 171,000,000 | 199,500,000 | 228,000,000 | 256,500,000 | 285,000,000 |
| $300 [2] to $5,000 | 177,000,000 | 206,500,000 | 236,000,000 | 265,500,000 | 295,000,000 |

[1] Computed by multiplying the total taxable wages for any one period and set of conditions by the specified tax rate.

[2] This $300 lower limit is used in accordance with the present California Unemployment Compensation and Unemployment Disability Compensation Acts, which exempt workers earning under $300 in any one year from the benefits and the taxes of those laws.

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[1] Final Report Assembly Health Care Investigating Interim Committee, p. 19.

[2] Senate Daily Journal, California Legislature (57th sess.), January 15, 1947, pp. 358–359.

*Simplified computation*[1] *of revenue from various tax rates on specified taxable wages in California, 1940, 1944, 1947*—Continued

(C) ON BASIS OF ANTICIPATED 1947 EMPLOYMENT, WAGES, AND TAXABLE WAGES

| Taxable wages | 3-percent tax | 3½-percent tax | 4-percent tax | 4½-percent tax | 5-percent tax |
|---|---|---|---|---|---|
| $300 [2] to $3,000 | $138,000,000 | $161,000,000 | $184,000,000 | $207,000,000 | $230,000,000 |
| $300 [2] to $4,000 | 142,800,000 | 165,600,000 | 189,400,000 | 213,200,000 | 237,000,000 |
| $300 [2] to $5,000 | 150,000,000 | 175,000,000 | 200,000,000 | 225,000,000 | 250,000,000 |

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[1] Computed by multiplying the total taxable wages for any one period and set of conditions by the specified tax rate.

[2] This $300 lower limit is used in accordance with the present California Unemployment Compensation and Unemployment Disability Compensation Acts, which exempt workers earning under $300 in any one year from the benefits and the taxes of those laws.

*Health insurance provisions which can be financed by specified taxes*

(A) WHERE THE STATE MEETS THE COST OF ADMINISTRATION, AND NO LARGE RESERVES SET UP

| Taxes | | Limited medical care plans the taxes will finance | | | | |
|---|---|---|---|---|---|---|
| | | Dependents | | Method of paying doctor | | |
| Rate | Income limit | Up to age 18 | Up to age 21 | Fee for service | Wholesale arrangements | Capitation |
| *Percent* | | | | | | |
| 3.0 | $3,000 | | | | | |
| | $4,000 | | | | | |
| | $5,000 | V | V | | | V |
| 3.5 | $3,000 | V | | | | V |
| | $4,000 | V | V | | | V |
| | $5,000 | V | V | | V | V |
| 4.0 | $3,000 | V | | | V | V |
| | $4,000 | V | V | | V | V |
| | $5,000 | V | V | | V | V |
| 4.5 | $3,000 | V | | V | V | V |
| | $4,000 | V | V | V | V | V |
| | $5,000 | V | V | V | V | V |

(B) WHERE 10 PERCENT OF CONTRIBUTIONS GO FOR ADMINISTRATION AND RESERVE

| Rate | Income limit | Up to age 18 | Up to age 21 | Fee for service | Wholesale arrangements | Capitation |
|---|---|---|---|---|---|---|
| 3.0 | $3.000 | | | | | |
| | $4,000 | | | | | |
| | $5,000 | | | | | |
| 3.5 | $3,000 | V | | | | V |
| | $4,000 | V | V | | | V |
| | $5,000 | V | V | | | V |
| 4.0 | $3,000 | V | | | | V |
| | $4,000 | V | V | | | V |
| | $4,000 | V | | | V | V |
| | $5,000 | V | V | | V | V |
| 4.5 | $3,000 | V | | | V | V |
| | $4,000 | | V | | V | V |
| | $4,000 | V | | V | V | V |
| | $5.000 | V | V | V | V | V |

NOTE.—A 5-percent tax will be adequate on any tax limit from $3,000 up, dependent children up to 21, and whether or not the State meets administrative expenses. It should be noted that the above estimates contemplate the furnishing of benefits according to the terms of the two compulsory bills considered at the previous session which have been referred to.

Based on its studies, the majority of the senate committee included in its recommendations the following:

"That there be established at once by the State of California a system of prepaid health insurance to protect the people of this State against the peril of catastrophic illness. Such a program should be limited, for the time being, to those cases where the duration of the illness is long or the cost of treatment great. The definition of 'catastrophic illness' is of necessity a matter for legislative determination."

The legislation based on the committee's recommendation is embraced in bills sponsored by Gov. Earl Warren and introduced in both houses.

The bills each propose a "compulsory" system of health insurance practically identical to the bills introduced in the previous session except that benefits are limited to those protecting the people of the State against the peril of "catastrophic" illness.

Despite the active championing of the measures by our Governor and plenty of publicity, little pressure was generated from the people and little support given by those groups which had been most active in support of the more comprehensive bills during the 1945 session. The assembly bill No. 1500 has not yet been set in committee for hearing, while its companion measure was tabled by the senate committee on governmental efficiency and economy.

During the present session the standing committee of the assembly on public health and safety was directed by resolution to study the cost phases of the current legislation.

We employed the same actuary as worked on the interim committee report, obtained more current data, and reported back to the assembly in March.

Since the report is short and refers directly to the costs of providing even a limited system of prepaid health insurance, and since it has not been published as a separate document, the report of the actuary is reproduced herewith.

It appears in the Assembly Daily Journal of the California Legislature (57th sess.) for April 1, 1947, page 39 and following. I believe the factual data contained will prove of value to your committee.

### REPORT SUBMITTED BY VIRGIL M. TRIFFIN, ACTUARY

This report contains the most recent available experience with reference to hospitalization of: (1) The Occidental Life Insurance Co., (2) Blue Cross Hospital Plan, (3) the Health Service System of San Francisco.

*Occidental Life Insurance Co.*

Through the cooperation of the Occidental Life Insurance Co., which opened its books to us at its home office in Los Angeles, a complete examination was made of its claim register. This examination, supplemented by runs on the company's tabulating equipment, was sufficient to provide the number of hospital claims and the number of members exposed to risk in the State of California.

Five groups were excluded in making our computations because either the complete claim information or the membership rolls were not currently available.

The records of groups and memberships therein for the year 1946 were as follows:

| | Jan. 1 | May 1 | Sept. 1 | Dec. 1 |
|---|---|---|---|---|
| Number of groups | 105 | 111 | 122 | 120 |
| Numbers of persons | 23,113 | 24.475 | 28,431 | 32,172 |

The averages for the year were 114½ groups, with 27,048 members.

Table 1, which follows, sets forth the claims experience during the calendar year 1946.

TABLE 1.—*Group hospitalization experience, Occidental Life Insurance Co., 1946*

| | | |
|---|---|---|
| (*a*) Life years exposure | | 27,048.0 |
| (*b*) Hospitalized cases: | | |
| Surgical cases [1] | 1,532 | |
| Medical cases | 623 | |
| | | 2,166.0 |
| (*c*) Hospital days | | 18,286.0 |
| (*d*) Cases per member (*b*)+(*a*) | | .08 |
| (*e*) Day per case (*c*)+(*b*) | | 8.44 |
| (*f*) Hospital days per member per year (*d*)×(*e*) | | .675 |

Of the 2,166 cases hospitalized, there were 27 where the number of days extended beyond the limits provided in the contracts under which the beneficiaries were insured. Some of the contracts in force provided for hospitalization up to 31 days and others up to 70 days. Under the 31-day contracts, there were 13 claims in which hospitalization extended beyond the limit; while under the 70-day contracts, there were 14.

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[1] Final report, Assembly Health Care Investigating Interim Committee. See pp. 31 and 32.

Membership in the groups was preponderantly adults, male and female employees.

*Blue Cross Hospital plan*

The experience of the Blue Cross Hospital plan was taken from its Nationwide statistical studies which were made available to us through the courtesy of the officers of the State organization.

These studies yield the pertinent data shown in the table which follows and covers a 6-year experience for the years 1940 to 1945, inclusive.

TABLE 2.—*Blue Cross hospitalization experience*

| Year | Admissions (cases per member) | | Hospital days (per member per year) | | Year | Admissions (cases per member) | | Hospital days (per member per year) | |
|---|---|---|---|---|---|---|---|---|---|
| | Adult males | Adult females | Adult males | Adult females | | Adult males | Adult females | Adult males | Adult females |
| 1940 | 0.08 | 0.10 | 0.84 | 1.18 | 1943 | 0.09 | 0.09 | 0.93 | 0.91 |
| 1941 | .07 | .10 | .70 | .99 | 1944 | .10 | .10 | .95 | .93 |
| 1942 | .085 | .105 | .84 | .96 | 1945 | .10 | .10 | 1.11 | .92 |

*Health Service System of San Francisco*

The Health Service System of San Francisco is a health service system for the municipal employees and the employees of the Board of Education of San Francisco. The plan under which such employees are insured provides medical, surgical, and hospitalization benefits for them and for their dependents, and for retired members.

Membership on the part of employees is compulsory while membership of dependents is elective and selective in that physical examination is required. Since physical examination on the part of employees is required as a condition of employment, the whole membership may be considered as select. Certain benefits are excluded, such as tonsillectomies and adenoidectomies for minor dependents; "no adult dependent or independent beneficiary is entitled to obstetrical service or service for complications of pregnancy"; nor are employed members entitled to hospitalization for the same.

We were furnished the material used to compile the table shown below by the office of the Health Service System of San Francisco. A separate table appearing on the next page shows the costs attending the hospitalization of members for the 12 months ending September 12, 1946.

TABLE 3.—*Group hospitalization experience, health service system of San Francisco, year ending Sept. 80, 1946*

| Membership | Number of subscribers | Number hospitalized | Total days hospitalized | Average days per patient | Days per member per year |
|---|---|---|---|---|---|
| Employed: | | | | | |
| Male | 7,539 | 564 | 4,823 | 9 | 0.64 |
| Female | 3,353 | 321 | 2,720 | 8 | .81 |
| Total | 10,892 | 885 | 7,543 | 9 | .69 |
| Adult dependents: | | | | | |
| Male | 86 | 6 | 47 | 8 | .55 |
| Female | 2,412 | 227 | 1,867 | 8 | .77 |
| Total | 2,498 | 233 | 1,914 | 8 | .76 |
| Children | 1,903 | 143 | 657 | 5 | .36 |
| Retired | 848 | 83 | 868 | 10 | 1.02 |
| Grand total | 16,141 | 1,344 | 10,982 | 8 | .74 |

*Comparison, by type of subscriber of hospitalization experience, 12-month period ending Sept. 30, 1946*[1]

| | Number of subscribers in group | Number hospitalized | Total days hospitalized | Average days per patient | Average cost per patient hospitalized | Cost per patient per day | Total cost |
|---|---|---|---|---|---|---|---|
| Members: | | | | | | | |
| Male | 7,539 | 564 | 4,823 | 9 | $98.75 | $11.55 | $55,696.50 |
| Female | 3,353 | 321 | 2,720 | 8 | 94.45 | 11.15 | 30,318.29 |
| Total | 10,892 | 885 | 7,543 | 9 | 97.19 | 11.40 | 86,014.79 |
| Retired: | | | | | | | |
| Under 62 years: | | | | | | | |
| Male | 179 | 13 | 152 | 12 | 123.93 | 10.60 | 1,611.06 |
| Female | 101 | 7 | 25 | 4 | 47.92 | 13.42 | 335.44 |
| Total | 280 | 20 | 177 | 9 | 97.33 | 10.99 | 1,946.50 |
| 62 years and over: | | | | | | | |
| Male | 369 | 38 | 427 | 11 | 125.94 | 11.21 | 4,785.80 |
| Female | 199 | 25 | 264 | 11 | 114.82 | 10.87 | 2,870.42 |
| Total | 568 | 63 | 691 | 11 | 121.53 | 11.08 | 7,656.22 |
| Total retired | 848 | 83 | 868 | 10 | 115.70 | 11.06 | 9,602.72 |
| Adult dependents: | | | | | | | |
| Under 62 years: | | | | | | | |
| Male | 60 | 4 | 30 | 8 | 100.60 | 13.41 | 402.40 |
| Female | 2,009 | 178 | 1,388 | 8 | 87.22 | 11.18 | 15,525.17 |
| Total | 2,069 | 182 | 1,418 | 8 | 87.51 | 11.23 | 15,927.57 |
| 62 years and over: | | | | | | | |
| Male | 26 | 2 | 17 | 9 | 103.75 | 12.20 | 207.50 |
| Female | 403 | 49 | 479 | 10 | 106.72 | 10.92 | 5,229.27 |
| Total | 429 | 51 | 496 | 10 | 106.60 | 10.96 | 5,436.77 |
| Total adult dependents | 2,498 | 233 | 1,914 | 8 | 91.69 | 11.16 | 21,364.34 |
| Minor dependents | 1,903 | 143 | 657 | 5 | 49.00 | 10.67 | 7,007.24 |
| Grand total | 16,141 | 1,344 | 10,982 | 8 | 92.25 | 11.29 | 123,989.09 |

[1] Health Service System of San Francisco.

In order to more readily compare the experiences studied we have prepared the table below in which the Blue Cross experience for 1945 is used:

TABLE 4.—*Comparative hospitalization experience*

| Experience studied | Hospital cases per member per year | Hospital days per member per year |
|---|---|---|
| Occidental Life | 0.08 | 0.675 |
| Blue Cross: | | |
| Male | .10 | 1.11 |
| Female | .10 | .92 |
| Health Service Plan of San Francisco | .08 | .74 |

### *Cost trends*

Our study thus far has been directed toward securing data reflecting current experience as to the incidence and duration of hospitalization. It will be seen, with reference to previous studies, that there is little variation from year to year in the incidence and the duration of hospitalization. Unit costs of hospitalization, however, have shown a steady upward trend.

The following determinations are not introduced here to establish hospital costs but to illustrate factually the current trend.

*Hospital costs per day*

BLUE CROSS

| | |
|---|---|
| 1945—First quarter | $9.20 |
| First half | 9.60 |
| Second half | 10.13 |
| 1946—First quarter | 10.30 |
| First half | 11.10 |

SAN FRANCISCO COUNTY HOSPITAL

| | Main hospital | TB hospital | Communicable disease, isolation |
|---|---|---|---|
| 1942–43 | $7.47 | $4.84 | $6.97 |
| 1943–44 | 9.08 | 5.79 | 5.87 |
| 1944–45 | 9.33 | 5.99 | 8.36 |
| 1945–46 | 9.33 | 6.67 | 6.59 |

HEALTH SERVICE SYSTEM, SAN FRANCISCO

| | |
|---|---|
| 1942–43 | $8.36 |
| 1943–44 | 9.45 |
| 1944–45 | 9.80 |
| 1945–46 | 11.29 |

15 CALIFORNIA HOSPITALS [1]

| | |
|---|---|
| 1940 | $9.20 |
| 1944 | 11.80 |

5 SOUTHERN CALIFORNIA HOSPITALS [1]

| | |
|---|---|
| 1940 | $9.14 |
| 1944 | 12.30 |

10 NORTHERN CALIFORNIA HOSPITALS [1]

| | |
|---|---|
| 1940 | $9.26 |
| 1944 | 11.41 |

[1] Final report, Assembly Health Care Investigating Interim Committee. See pp. 31 and 32.

*Evaluation of the costs of providing benefits under A. B. 1500*

Reference is made to assembly bill No. 1500 as introduced and printed January 30, 1947. Article 3 of the bill, secs. 50 and 51, provides the following services:

1. Up to 100 days hospitalization for each continuous period of disability.
2. Medical services by a physician or surgeon rendered in a hospital or following hospitalization.
3. Certain treatment by dentists when performed in a hospital.

Hospital services as detailed in section 52 (a), (b), (c), and (d) include—

(*a*) Bed and board in a ward or semiprivate room. Services of a dietitian, general nursing care, use of operating rooms, anesthetics, and surgical supplies. Use of cystoscopic rooms.

(*b*) Drugs, biologics, bandages, dressings, oxygen, blood, and plasma, as required during period of hospitalization.

(*c*) Care of new-born infants during such period as mother remains in the hospital.

(*d*) Laboratory services, including chemical, bacteriological, physical, diagnostic, and therapeutic X-ray, and such other laboratory or related services as are ordinarily provided by a hospital.

Section 53 provides that the above laboratory services may be rendered to persons outside of the hospital in standard approved laboratories approved by the authority when necessary and prescribed by the physician as required by the nature of the case.

In section 54 it is provided that the authority may require in cases other than surgery or obstetrics that the beneficiary pay for the first 2 days of hospitalization or a portion of the laboratory fees, not to exceed $10.

Sections 55 and 56 provide for extension of services but cannot be evaluated here since they are contingent on the condition of the fund.

In article 7, section 158, it is provided that not more than 6 percent of the money deposited in the fund may be expended for all expenses by the authority and departments of government incident to carrying out the provisions of the act.

Those eligible to receive benefits under the act are employees and each of their dependents.

The subjoined table exhibits an estimate of the costs of the above listed benefits under the following conditions:

(*a*) Medical services at 1945 cost levels.

(*b*) Laboratory and X-ray services at 1945 cost levels.

(*c*) Hospitalization at 1947 cost levels.

(*d*) Incidence and demand for service comparable to that experienced by prepaid medical care plans operating in California.

(*e*) A membership consisting of equal numbers of men between the ages of 18 and 65, women between 18 and 65, and children under age 18.

(*f*) No expansion or reduction of the above benefits by action of the authority.

*Determination of possible costs for certain hospital and medical services—Annual cost per person*

| Service | Reference, Assembly bill 1500 | Males, age 18 to 65 | Females, age 18 to 65 | Children, age 0 to 17 | Total, man, woman and Child |
|---|---|---|---|---|---|
| 1. Medical: | | | | | |
| (*a*) Doctor's calls | Art. 3, sec. 51 (a) | $3.30 | $5.10 | $1.68 | $10.08 |
| (*b*) Surgical | do | 5.33 | 10.62 | 4.78 | 20.73 |
| (*c*) Dental | Art. 3, sec. 51 (b) | (?) | (?) | (?) | (?) |
| 2. Hospital, including laboratory | Art. 3, sec. 52 (a), (b), (c), (d). | 11.25 | 16.75 | 5.63 | 33.63 |
| 3. Laboratory, outside hospital | Art. 3, sec. 53 | 5.29 | 5.29 | 2.65 | 13.23 |
| 4. Maternity, hospital and physician (not included under hospital or medical above). | | | 13.50 | | 13.50 |
| Total | | 25.17 | 51.26 | 14.74 | 91.17 |
| 5. Expenses, 6 percent of gross deposits | Art. 7, sec. 158 | | | | 5.83 |
| Total cost | | | | | 97.00 |

The table has been prepared to show the cost individually for an adult male, an adult female, and a child; the total column shows the cost for a group consisting of three people: an adult male, an adult female, and a child. The three people do not, necessarily, represent a family although it is estimated that among the civilian population of California the average family consists of 3.1 persons.

NOTE.—Following references are to "Final report of the assembly health care investigating interim committee" H. R. 295, 1945:

1 (a) Table 37, page 69.

1 (b) Page 101 (costs for "Employed women" and "Unemployed married women" averaged).

1 (c) No cost data available.

2. Page 94, table 52, division 3, with cost per hospital day (ward care) assumed to be $12.50. Division 3 selected because contemplated coverage is for all eligible groups indiscriminately under "fee for service."

3. Page 88, for adult. Page 100 for child.

4. Based on expectation of 18 births per year per 1,000 population. Cost per birth: 10 days in hospital, at $12.50, $125; physician's fees, $100; total, $225.

(Subsequently Senator Pepper addressed the Chair as follows:)

Senator PEPPER. Mr. Chairman, I should like to have inserted in the record immediately following the testimony of Mr. Geddes on June 4, 1947, some newspaper reports and editorials which reflect the need for additional training facilities to train more dentists and for an adequate dental care program for all children without a means test. These editorials and reports are in sharp contrast to the views of officials of the American Dental Association who testified here on May 29, 1947. For example, the Brooklyn Eagle of March 14, 1947, reports that Dr. Hillenbrand, general secretary of the association asserted the need for more facilities to train dentists and the responsibility of society as a whole to meet the Nation's health needs. He said that adequate dental care for all children would reduce the Nation's dental problem by one-third in 10 years and that the only source of financing any such program was the Government.

The Herald-Journal of Syracuse, N. Y., on February 4, 1947, reported a statement of the Dental Society of New York State on the insufficient number of dentists available to fill 500,000,000 existing cavities in America. The Oklahoman of April 15, 1947, reports Dr. Sterling Mead as having stressed the need for free dental examinations and care of every public school child without a means test, although he emphasized the nondesirability of free dental service for everyone.

The San Francisco Chronicle of January 28, 1947, reports California's need for expansion of the State's dental training facilities to meet its dental manpower requirements by Dean Willard C. Fleming of the College of Dentistry of the University of California.

[From the Eagle, Brooklyn, N. Y., March 14, 1947]

### Calls Federal Aid Vital to Dentists' National Health Aim

Organized dentistry's health programs are being "held up" by a lack of adequate public support, Dr. Harold Hillenbrand, general secretary of the American Dental Association, told the Kings County Dental Society last night. He urged increased Federal aid to State and local health plans to meet a "growing public demand" for extended health service.

Speaking to approximately 300 Brooklyn dentists in the Kings County Medical Society headquarters, 1313 Bedford Avenue, Dr. Hillenbrand warned, however, that there is a sharp distinction between Federal aid and Federal control. The Wagner-Murray-Dingell bill for federalized medicine he termed "unsound," but said the Taft-Smith-Ball-Donnell bill, which would permit medical and dental programs to be controlled at the State level, was a "far-reaching" piece of legislation.

Asserting that immediate action was necessary to meet the Nation's "vast" dental health needs, he said responsibility is that of society as a whole and not that of professional people alone.

The A. D. A., Dr. Hillenbrand said, is bringing a three-point program designed to reduce the size of the problem by increased research, increased dental health education and increased care.

Adequate dental care for all children now would reduce the Nation's dental problem by at least one-third in 10 years, he declared.

"It is obvious that such a program, to be truly effective, cannot be supported out of funds provided by the dental profession. The only source seems to be Government."

The need for more education is pointed up, he said, by the fact that "fewer than one-half of the American people use a toothbrush."

The profession was also concerned, Dr. Hillenbrand asserted, with the need for more facilities for training of dentists. The Nation's dental schools now have a capacity of only about 2,500 graduates a year, he said.

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[From the Herald-Journal, Syracuse, N. Y., February 4, 1947]

### Need for Dentists

Now the Dental Society of New York State is informed that 500,000,000 cavities in aching teeth need to be filled in the United States. That as Calvin Coolidge would say, is a "powerful lot of cavities," but that isn't all. About 112,000,000 new cavities develop each year and there are not enough dentists to fill these, to say nothing of 500,000,000 old cavities. Hence national dental insurance is impossible, the dentists say.

That looks rather serious to the man who is looking up a dentist's telephone number to get a cavity filled some time within the next 6 weeks. It is serious and there is great need for more and more dentists. Within a generation or more, teeth have had better care and some provision is needed to continue that care. As for national dental insurance that seems out of the question. The public can help itself to a considerable degree. It was brought out at the meeting that most damage to teeth is during or shortly after meals and immediate brushing afterward is important. With 112,000,000 new cavities a year, it looks as if the dentist shortage is a real problem.

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[From the Oklahoman, Oklahoma City, Okla., April 15, 1947]

## Speaker Urges Dental Program for United States Youth

The Nation's shortage of dentistry is greater than its shortage of dentists, according to Dr. Sterling V. Mead, Washington, D. C., president of the American Dental Association.

Dr. Mead, who will speak Tuesday at sessions of the State dental society convention here, declared that setting up a dental program for children is the most urgent job facing the ADA.

"We are interested in extending dental health to more people. But we are particularly interested in taking care of the children," Dr. Mead said.

"A good children's health day is every day—not just once a year."

### DENTAL RESEARCH PUSHED

Another major task the national association has taken on this year is the promotion of dental research.

"It is far more important to find the cause of dental diseases than to treat the end result," he declared. "There are not enough dentists in the world to take care of all the cavities. We should start with preventive dentistry."

Bills which would give the dentists aid in reaching both these objectives now are pending in congress and Dr. Mead was optimistic about their outcome.

One bill would set up a $2,000,000 research foundation. So far, research in the dental field has been undertaken and paid for by the profession. The national society now sponsors two research programs.

### STATE GRANTS SOUGHT

Other bills, one of which is sponsored by the dental association, would give grants-in-aid to States, the individual State matching Federal funds to set up adequate dental programs for children and for the underprivileged.

"We do not believe in free service to everyone," Dr. Mead continues. "That leads to compulsion, collectivism and socialism. But we think every school child, from the first grade through high school, should have a free examination and is entitled to dental care whether or not he as the money to pay for it."

In Washington, D. C., he said, every child in school gets a free examination. If he is unable to pay for work which should be done, he goes to a clinic financed by the district.

### MEAD IS A SPECIALIST

Dentistry is not expensive in the beginning, he stressed. It is when complications set in that ill health and high costs result—"and remember, today's children are tomorrow's adults."

Dr. Mead, a native of Hutchinson, Kans., is a specialist in oral surgery and runs a dental hospital in Washington. He is a past vice president of ADA and has been chairman for several years of the association's legislative committee.

[From the Chronicle, San Francisco, Calif., January 28, 1947]

## DENTISTS TOLD THEIR RANKS NEED FILLING

The increase in the number of California dentists has lagged far behind the State's population increase, Dean Willard C. Fleming of the College of Dentistry, University of California, told the fifty-first annual meeting of the school's alumni yesterday.

The State's three dental schools, he said, now can turn out 170 graduates yearly. But 189 dentists are needed to replace those who retire from practice each year.

Despite the fact that the State is leaping in population, due largely to people coming from other sections, competent dentists do not seem to be joining the westward migration, he said.

In the past 6 years, said Dean Fleming, 858 applicants attempted to pass the State examinations, but only 319 qualified under the rigid requirements.

### MANY FAIL TESTS

California, with a high per capita income, has long led the Nation in the percentage of dentists compared to population.

For instance, 6 years ago the national average was 1 to every 1,850 persons. In California the average was 1 dentist to less than 1,450 persons, he told the more than 700 dentists attending the conference in Hotel St. Francis.

The State's problem could be solved, he declared, by an expansion in present training facilities. Enough qualified men desire to study for the degree, but cannot be accommodated.

Last September, 290 students applied for admission into a freshman class limited to 60, he said. Already 150 students who have their two years of predental work behind them have asked to enroll next fall.

### FACILITIES LACKING

The situation is much the same at San Francisco's College of Physicians and Surgeons, which can handle 54 students in the freshman class, and at University of Southern California, which has a first-year capacity of 100, he said.

San Francisco men filled all but one of the group's offices. Dr. Gordon M. Fitzgerald, University of California professor, became president; Dr. Walter Harrison, dental surgeon, was named president-elect to succeed Fitzgerald next year; Dr. Ernest L. Johnson, orthodontist, became treasurer; Dr. John T. Scully, dentist, secretary; and Dr. William S. Smith, editor of the group's news letter.

Dr. Harold Broderick, San Jose oral surgeon, was elected vice president.

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[From the Times, Huntsville, Ala., April 8, 1947]

## DENTAL DELAY

Most Americans don't obey the injunction to see the dentist twice a year—or even once a year. Apparently were just plain backward about the matter.

Dr. Howard A. Rusk, writing in the New York Times. asserts that only about 25 percent of the population gets regular dental care. The rest of the people visit dentists only in emergencies—or not at all.

Right now, Dr. Rusk says, half a billion fillings are needed in this country, and dentists would have to extract 25,000 teeth a year if all adults who have teeth beyond repair should decide to have the matter attended to.

If these figures give the impression that American teeth are in a bad way, that's right. They are.

We heard a lot during the war of selective service's findings as to dental health. One third of the Nation's dentists were needed to make men fit for military service.

But the vast amount of work done by the Dental Corps made hardly a dent in the over-all problem in this country. And chances are that a majority of the men who got proper dental care in service haven't visited a dentist since—and won't until they're forced to do so.

This aspect of the Nation's health problem is caused in part by the low income of many people, and by other factors which can't easily be corrected. But it is also caused by just plain neglect of an important matter by a lot of people who ought to know better—who, in fact, do know better.

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[From the Register, Des Moines, Iowa, May 6, 1947]

## DENTAL AID FOR CHILDREN ASKED

"Local and State dental health programs are needed by Iowa children, three-fourths of whom are not getting enough dental care, Dr. Lon W. Morrey, Chicago, Ill., declared here Monday evening.

"Only about 125,000 of the State's 500,000 children between 5 and 16 are getting attention they need," said Dr. Morrey, editor of the Journal of the American Dental Association.

### CALLS FOR FUNDS

He spoke to the dental health committee of the Iowa State Dental Society at the Des Moines Club. The society is holding its eighty-fifth annual convention in Hotel Fort Des Moines.

The speaker urged that State and local health departments be given funds for dental health education and service programs for children throughout the State.

"Iowa's children need more than 3½ million dental fillings and 866,000 extractions," Dr. Morrey declared.

### SPEAKERS

Other speakers at the 2-day gathering will include Dr. Harold Hillenbrand, Chicago, general secretary of the American Dental Association, and Dr. Vincent R. Trapozzano, Philadelphia, Pa.

Delegates were registering Monday afternoon while advance registration for the Iowa State Dental Assistants Association convention was under way in Hotel Savery. Sessions of both conventions begin today.

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[From the Chicago Defender (Negro), Chicago, Ill., April 12, 1947]

## COLLEGE FUND REVEALS CRITICAL SHORTAGE OF PROFESSIONALS

NEW YORK.—Among the 70,000 dentists in the United States only 1,400 of them are Negroes.

This was one of several surprising revelations made last week by the united Negro college fund as it furthered its drive for $1,300,000 for its 33 member colleges this year.

The statistics released after investigation by UNCF showed further that of the 400,000 nurses in the country, only 8,000 of them are Negroes. Of the 176,000 lawyers, only 1,000 are Negroes.

William J. Trent, Jr., UNCF executive secretary, in reporting that there is but 1 Negro physician for every 4,000 Negro people as compared to 1 white doctor for every 900 of population, said that there is immediate need for 13,000 more Negro doctors.

### ONE TEACHER, 201 PUPILS

The investigation also disclosed 1 white school teacher for every 122 children in American schools, but only 1 Negro for every 201 pupils in the Nation's separate schools. Trent said that more than 42,000 Negro teachers are needed.

"The fund, in its campaign for Negro colleges is not defending or attacking the separate school system," Trent emphasized.

"It is trying to make clear the size of the problem and the amount of educational work that must be done if we do not fall below even present standards."

The Negro represents between one-eleventh and one-tenth of the total population, and the number of professionals in teaching, law, medicine, and dentistry therefore falls far short of a proportionate ratio.

A debate between teams representing Cambridge University of England and Lincoln University of Oxford County, Pa., will be sponsored by the UNCF on April 19 at Times Hall, with Abdool Marraj, of Demara, British Guiana, pitted against Ian S. Lloyd, a white student from Natal, Union of South Africa, Trent announced.

Frank M. Totton, vice president of the Chase National bank, will again serve as chairman of the UNCF's national drive for $1,300,000, and John D. Rockefeller, Jr., will be chairman of the national advisory committee, Trent said. He revealed that $6,000 has already been subscribed to the fund by students of Yale University and Wesleyan and Carleton Colleges.

Sarah Lawrence and Princeton students will support the drive this year, Trent said. Lincoln University was founded in 1854 "as a protest against the authorities at Princeton who denied admittance to Negro applicants."

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[From the Californian, Bakersfield, Calif., January 28, 1947]

### Five Hundred Million Cavities

Have you a toothache? If so, you may be comforted by the news that there are 500,000,000 other aching teeth in the Nation, but what will bring you small peace of mind indeed is the news that there are only half the dentists needed in the United States to treat the misery arising from toothache and other dental maladies.

Research by the American Dental Association has unearthed the painful fact that all the dentists in the Nation are sufficient to care for only half of the 112,000,000 new cavities which occur among Americans above the age of 6 and consequently the old cavities just have to be ignored.

This may be along the lines of your experience in trying to obtain a dental appointment during the past 4 years and it is an indication of what is needed in the United States, along with more doctors. The average health of Americans is not good, although it is better than inhabitants of other countries, and the stresses of bad housing, postwar adjustments and other strains impose a burden on general health as well as mental poise of individuals. Adequate dental and medical care may well be a goal of postwar society in addition to new cars, nylons and lesser necessities.

Senator Smith. If there is no further business, the committee will adjourn until 9:30 o'clock tomorrow.

(Whereupon, at 12:10, the committee adjourned until 9:30 a. m., Thursday, June 5, 1947.)

# NATIONAL HEALTH PROGRAM

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THURSDAY, JUNE 5, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met, pursuant to adjournment at 9:30 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Smith, Murray, and Pepper.

Senator Smith. The committee will please come to order. The first witness this morning is Dr. Samuel Alexander of New Jersey. I will ask the doctor if he will come to the witness chair with his associates. I am more than happy to welcome you, Doctor, and your colleagues from my native State of New Jersey and hear your testimony on this bill. Before you begin, Doctor, I wish you would outline for the record your biography and qualifications as a witness.

## STATEMENTS OF DR. SAMUEL ALEXANDER, PAST PRESIDENT, NEW JERSEY STATE MEDICAL SOCIETY, PARK RIDGE, N. J., ACCOMPANIED BY DR. FREDERIC J. QUIGLEY, EXECUTIVE SECRETARY, NEW JERSEY STATE MEDICAL SOCIETY, UNION CITY, N. J., AND DR. NORMAN M. SCOTT, MEDICAL DIRECTOR, MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY, NEWARK, N. J.

Dr. Alexander. I am Dr. Samuel Alexander of Park Ridge, N. J., long-time member and trustee and recent past president of the Medical Society of New Jersey. Dr. Frederic J. Quigley of Union City is a long-time member and trustee, officer, and past president of the Medical Society of New Jersey. He is presently executive secretary of the committee on legislation of the Medical Society of New Jersey. Dr. Norman M. Scott, of Maplewood, N. J., is the executive vice president of the Medical Society of New Jersey in charge of problems relating to the distribution of medical care. Formerly Dr. Scott was an officer of the Medical Corps of the Regular Army for 22 years, being retired in 1938 with the rank of lieutenant colonel.

Other members of our delegation present today are Dr. Royal A. Schaaf, resident of Newark and present president of the Medical Society of New Jersey; Dr. J. Hornberger, president elect, of Roebling, N. J., and Dr. Vincent Butler of the Medical Society of New Jersey. He resides in Jersey City. I have asked Dr. Quigley and Dr. Scott to sit at the table. They can be helpful in answering questions relating to the field in which they have special knowledge and experience.

Senator SMITH. Doctor, in your testimony, are you reflecting your own personal view or the views of the Medical Society of New Jersey?

Dr. ALEXANDER. I am reflecting the views of the Medical Society of New Jersey. My associates and I are expressing the views of the Medical Society of New Jersey. We have 5,300 doctors in our association who are all residents of New Jersey.

Senator SMITH. Are they pretty well distributed throughout the State?

Dr. ALEXANDER. Practically every community in the State has at least one doctor, and we have large cities, such as Newark, Jersey City, Paterson, and Camden, in which we have a multitude of doctors. I might say in Essex County we have at this time approximately 1,500 members. In Hudson County, we have more than 600 members. In Bergen County we have more than 400 members. The ratio distributed throughout the State is based on the population and need.

Senator SMITH. Then you would say that the society is really very representative of the entire medical profession in the State of New Jersey.

Dr. ALEXANDER. I might say five-sixths of the doctors in the State are members of the Medical Society of New Jersey, and of the other sixth, many of them are not in active practice.

Senator SMITH. All right, Doctor, go ahead.

Dr. ALEXANDER. Through the courtesy of Senator H. Alexander Smith, representatives of the Medical Society of New Jersey, together with a delegation of the New York Academy of Medicine and a few physicians from other States were afforded the opportunity, December 28, 1946, of participating in a conference with Senators Taft, Smith, Ball, and Donnell, sponsors of S. 545, preparatory to the writing of this measure.

At this conference, representatives of the Medical Society of New Jersey made several suggestions relative to provisions of the bill. Two or three of these, as we learned at the time, had already occurred to the sponsors or had been previously proposed by representatives of the American Medical Association. The fact, however, that the majority of the recommendations we made at this conference were incorporated in the present draft of S. 545 leads us to hope that the suggestions and criticisms we now offer may prove, likewise, helpful to this committee.

The Medical Society of New Jersey is in accord with organized medicine throughout the Nation in its desire to have a National Department of Health established at the earliest practicable moment. As this most desirable objective appears unattainable at this time, we desire to record our approval of the purposes of title I of S. 545 and also of its provisions, with the exception of those to which we shall presently suggest amendments.

We sincerely believe that the sponsors of this bill in proposing title I rendered a signal public service in their recognition of the need of centralizing all the activities of the Federal Government relating to health in a single agency concerned solely with public health.

If the full "purpose of the agency" is to be realized—section 102 (a), page 3—by "centralizing in the agency the activities of the Federal Government relating to health," we are of the opinion that all medical research sponsored by the Federal Government should be within the framework of the National Health Agency. Recognition of the desirability of such provision is more or less implicit in section 108 (3), page 12. To effect this purpose would require an addition to section 104 (a), page 8, to include "The Office of Medical Research," and the deletion of subsection (3) of section 108, page 12.

Senator SMITH. Doctor, I might comment there that we recently passed in the Senate the so-called National Research Foundation bill which has a special provision for research in the medical sciences. It provides also for research in cancer and heart disease. The thought is to put the research functions of all these scientific groups in that National Science Foundation rather than in this separate bill. I just mention that in passing because it may mean a little change in that respect.

Dr. ALEXANDER. We would suggest rephrasing section 104 (d), page 9, using section 715 (a), page 24, as a model, so that (*a*) "the head of the Office of Maternal and Child Health" shall consult with the Advisory Council, and (*b*) that the Council shall be composed of eight members, at least four "of whom shall be doctors of medicine who are specialists in obstetrics or pediatrics."

In the main, the remainder of our comments on this bill are concerned with the purposes and provisions of title VII—General Medical Service for Families and Individuals with Low Income.

We are of the conviction that the application of "Part A, Medical Care Survey," and "Part B, Medical Care Services" should be limited to those States in which there is demonstrated financial inability to carry out the purposes of parts A and B without Federal aid.

While as a group, of course, we cannot qualify as experts in government, the elementary civics which we were taught, and which most of us still believe, placed the primary responsibility of providing the essential needs of the individual, if an adult, upon the individual himself, and if the head of a famly, of providing for his dependents. Financial inability of the individual to provide essential needs for himself and his family, food, clothing, shelter, or medical care, then places the responsibility upon the community, within the limits of its resources, and becomes a part responsibility of the State if and when the resources of a community are inadequate.

We, like many other citizens, are worried over the present tendency of the individual to lean upon Government; of the community to lean upon the State; of the States to lean upon the Federal Government. We are concerned over the current trend in Government which makes this situation possible. And we wonder, too, what the ultimate effect will be upon the character of the people, and upon our form of Government.

Returning to the discussion of title VII of S. 545, it is our opinion that appropriations for the purpose of conducting the surveys contemplated by part A and for medical care services as provided in part B, should be limited to the 10 or 11 States of the South and Southwest whose economic conditions and relatively poor health records indicate the need of Federal assistance. And we are inclined to believe it would be more judicious to await the surveys and their evaluation in those States before fixing a definite appropriation for medical care services in this group of States.

To assume that the wider availability in medical care services in these 10 or 11 States of the South and Southwest, made possible by

Federal financial assistance, would result in marked improvement in the health of the people of those States would indeed be a fallacious deduction.

Laudable as the purposes of this title of the bill are, they must be viewed in proper perspective. How much or how little a State may need in the way of medical care services depends to a large degree on related health factors, The Social Security Board, in its Ninth Annual Report, page 26, states: "The health of a population depends upon many factors, such as income, education, sanitary and medical facilities, culture, social control, climate and special phases of the environment."

Statistics as to the above-mentioned health-related factors must of necessity be considered in planning for improvement of medical care services.

Of the related factors just mentioned, the most important is economic. According to a Survey of Current Business (23. 1–13) United States Department of Commerce, June 1943, based upon 1942 income payments, the average per capita income in the United States was $852. The lowest per capita income was in Mississippi—$407; the 10 States with the lowest incomes are in the South and Southwest.

Infant mortality is one of the best single indices of health and medical control. High infant mortality is a conspicuously regional situation since all except 1 of the 11 States with highest rates are located in the South or Southwest.

Control of infectious and contagious diseases requires not only medical care, but community control as well, and especially social control of individuals and families in the community by means of isolation, immunization and eradication of sources of infection. The distribution of deaths from infectious and contagious diseases is markedly regional. All the States with the worst records are in the South and Southwest, while the States with the best records are 7 Northeastern, 4 North Central, and 1 Western State.

Since tuberculosis has been nearly conquered by man, its presence to any degree in a community or State (except in case of migration) will generally indicate a lag in medical and environmental controls. The regional distribution of death rates from tuberculosis is shown by the fact that all except one (California) of the 12 States with highest rates are southern or southwestern States.

Implicitly title VII premises the assumption that all States need financial assistance from the Federal Government to carry out the purposes of the title. It is our considered opinion that the majority of States do not need and should not be proffered Federal aid.

We speak of New Jersey because we know it best, and because, generally speaking, it is fairly representative of the economic and health conditions of the States in the middle Atlantic area. New Jersey is a wealthy State. The survey published by the Department of Commerce in 1943, previously referred to, according to income payments in 1942, indicated that with the exception of Nevada, our State had the highest per capita wealth of any in the union. New Jersey, we feel sure, is well able to provide and to improve its medical care services without Federal assistance.

We wish to record a few facts and figures as to medical services and related health factors within our State, in the hope that after further study of conditions of other States, the committee may conclude that it is desirable to modify the present philosophy of title VII as to grants-in-aid to the States.

As previously noted, infant mortality is one of the best single indices of health and medical control. Statistics of 1940 disclose that only three States had a lower number of infant deaths than New Jersey. And no State had a lower death rate from infectious and contagious diseases.

In 1939 the Medical Society of New Jersey attempted to gain some idea as to the lack of availability of medical services within our State. The society's purpose was well publicized by the press and radio for several weeks, and all persons who had been unable to secure needed medical services were asked to communicate with the executive offices of the society. At the conclusion of the survey, 122 letters had been received from persons complaining of inability to receive medical attention. Every complaint was carefully investigated. In the majority of instances, the difficulty was not inability to secure the medical services thought to be needed, but lack of knowledge as to where they could be obtained. Of the 122 complaints registered throughout the State—and New Jersey has a population of over 4,000,000—only 4 appeared to be legitimate.

New Jersey, spearheaded by the Cancer Control Committee of the State Medical Society, now has an integrated, soundly based, and steadily developing cancer-control program, to which the medical profession, the State Department of Health, and the American Cancer Society are all contributing, within their proper scope of function.

We speak with some pride of two programs in operation in our State designed to relieve the financial strain of medical care and hospital services to people of modest income: The Hospital Service Plan of New Jersey and Medical-Surgical Plan of New Jersey. The Hospital Service Plan of New Jersey, incidentally the first State hospital service plan to be organized, steadily expanding, now has an enrollment of over 1,000,000 persons. Medical-Surgical Plan of New Jersey, sponsored by the State Medical Society, has an enrollment of over 100,000. By sagacious management it has avoided financial difficulties. This organization is now on a firm footing and its more rapid expansion may be anticipated.

The Medical Society of New Jersey is responsible for still another organization: Medical Service Administration of New Jersey. The principal purpose of this organization is to develop experimentally, and to operate, plans and procedures to be administered at a local level, designed to improve the character and availability of medical care services to the medically indigent and indigent.

Three years ago, at the request of the city of Newark, Medical Service Administration undertook to provide at home medical services for the indigent of that city, and shortly thereafter, for the medically indigent also. Operation of this plan, which ensures free choice of physician, has been responsible for improved medical services to persons in these categories. That they are free to call the physician of their choice has proved most satisfying to them and has had a distinctly beneficial effect upon their morale. The plan is mutually satisfactory to the administrative officials of the city of Newark and to the medical profession; and has proved to be more economical than the old method of providing these services by city physicians.

The attached exhibits detail some of the measures in operation in our State designed to meet the objectives envisioned by title VII. The steady progress being made toward these objectives, and the lack of financial need by the State, convince us that title VII of S. 545 should not apply to New Jersey, nor to other States with comparable resources.

Organized medicine in New Jersey is aware of its responsibility of leadership in the evolution of means to make increasingly available a high quality of medical care to all the people of the State, and, of the necessity, for full attainment of this purpose, of cooperation by the medical profession, voluntary agencies and governmental agencies within the State.

The Medical Society of New Jersey is in full accord with the aims and purposes set forth in S. 545, with the exception that we firmly believe that grants-in-aid to the States by the Federal Government should be limited to those States where need has been demonstrated.

I now offer the nine exhibits which are mentioned in this statement for inclusion in the record.

(The papers referred to are as follows:)

### Exhibit

For many years the Medical Society of New Jersey and its members through its committees have approved of and cooperated in the programs of all official and nonofficial health and welfare agencies of the State to develop adeqate public health and medical care services for the people of New Jersey. Some of these activities are as follows:

I. State health department program: A. Two hundred and seventy-four baby keep-well stations of which 174 are supervised by the State and operated by matched funds, and 100 operated by municipalities. Each clinic session attended by a member of the society who by training and experience is particularly fitted for this work.

B. Sixty mental hygiene clinics throughout the State, 40 of which are operated by State funds, and 20 operated by hospitals in 7 of our counties. Each clinic session attended by 1 or more recognized neuropsychiatrists.

C. Tuberculosis clinics, some conducted at county tuberculosis hospitals, others by State tuberculosis hospitals, and others under auspices of New Jersey Tuberculosis League. Each clinic session attended by physicians accomplished in the diagnosis and treatment of tuberculosis.

D. Throughout the State are located 40 health department distributing stations at which are available vaccines, sera, blood plasma, and antibiotic without charge. These stations also accept bacterial cultures for examination and blood for Wasserman tests.

II. New Jersey municipal aid administration: Through this official agency State funds are available to all municipalities for medical care of the indigent. The present program covers municipalities representing over 90 percent of the population of the State. Physicians in all municipalities cooperate in this program.

III. The following State agencies providing medical care on a categorical basis:

- (*a*) New Jersey Commission for the Blind.
- (*b*) New Jersey Crippled Children's Commission.
- (*c*) New Jersey State Board of Children's Guardians.
- (*d*) New Jersey Old-Age Assistance Commission.
- (*e*) New Jersey Rehabilitation Commission.
- (*f*) New Jersey Workmen's Compensation Commission.

IV. American Cancer Society, New Jersey division: Twenty diagnostic-therapeutic cancer clinics and 10 diagnostic cancer clinics have been established throughout the State. Each clinic is conducted in a hospital, each session attended by physicians on medical staff of the hospital under the chairmanship of a specialist in the treatment of cancer.

All cases referred to clinics from physicians as indigent or medically indigent persons are given free service.

New Jersey Society of Clinical Pathologists cooperate, rendering free service for diagnostic examination of biopsy specimens referred from private physicians in cases involving indigent and medically indigent patients. Seven thousand specimen containers were expended in this program last year.

During 1946 the Cancer Society expended $300,000 in New Jersey for the development of its clinics and training of personnel. It has sufficient funds without State or Federal aid to carry out its planned program.

1, 2. We attach as exhibit No. 1 and No. 2, The Cancer Program of New Jersey, Part 1 and Part II.
3. List of cancer clinics conducted by general hospitals in New Jersey.
4. Details of approved projects in New Jersey, by counties.
5. Remarks of Hon. Chapman Revercomb of February 28, 1947, on the New Jersey cancer program, contained in the Congressional Record of Eightieth Congress.

V. Hospital service plan of New Jersey: A voluntary, nonprofit organization providing protection against hospital expense to over 1,000,000 people with the cooperation of the medical profession and 200 hospitals under contract as cooperating hospitals.

VI. Medical-surgical plan of New Jersey: A nonprofit, voluntary, prepayment, medical-care plan, organized by the Medical Society of New Jersey, for the purpose of assisting persons overtaken with serious illnesses by providing benefits for services rendered by physicians to persons admitted to hospitals for treatment and as a means of providing complete payment for eligible services rendered to persons with below-average incomes. There are 3,400 participating physicians in New Jersey who have agreed to carry out the provisions of the plans contract with its subscribers. Enrollment in the plan as of April 30, 1947, was 104,840 persons. We present as exhibit No. 6, Performance of Operations, report of this plan as of April 30, 1947.

VII. Medical Service Administration of New Jersey: A nonprofit medical service corporation organized by the Medical Society of New Jersey for the purpose of studying the problems of the low-income and indigent population and evolving plans to meet their medical care needs with or without the aid of tax money.

Under the provisions of a contract between Medical Service Administration and Veterans' Administration, medical care is available to the veterans of New Jersey for service-connected disabilities by physicians of the veterans' choice.

The Farm Security Medical Care Plan, sponsored by the Federal Department of Agriculture for the benefit of low-income farmers being rehabilitated by the Federal Government, has been operated by Medical Service Administration for 6 years.

The city of Newark Medical Plan, designed to meet the needs of the indigent and medically indigent of the city of Newark, has been operated by medical service administration since 1943. We particularly call attention to the committee to this plan as an example of a satisfactory solution of the medical-care problem of the indigent and medically indigent through the cooperation of organized medicine and official health agencies. We offer as exhibit No. 7 a copy of a pamphlet titled "Implementing the National Health Program of the American Medical Association in New Jersey" in which is presented an outline of this plan, and 8 and 9, copies of statements regarding the plan submitted by the Honorable John A. Brady, director of public affairs for Newark, and Charles V. Craster, M. D., health officer of Newark.

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## THE CANCER PROGRAM IN NEW JERSEY

### PART I. DIAGNOSTIC AND THERAPEUTIC CANCER CLINICS

Prepared by the Advisory Committee on Cancer Control,[1] the Medical Society of New Jersey

During the last decade much interest has been manifested among physicians in the establishment of diagnostic and therapeutic cancer clinics in connection with general hospitals.

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[1] Dr. William O. Wuester, chairman; Dr. Otto R. Holters, vice chairman; Dr. Emil Frankel, consultant; Dr. Joseph I. Echikson; Dr. H. Wesley Jack; Dr. Joseph H. Kler; Dr. Thomas B. Lee; Dr. W. James Marquis; Dr. Leonid S. Snegireff.

When well organized and adequately staffed, these clinics are enthusiastically received by the local medical profession. They represent our most effective means of combating cancer by bringing into close cooperation the general practitioner, the surgeon, the radiologist, and the pathologist.

### *The general practitioner's role*

Among the medical men interested in cancer, the general practitioner is the most important. He sees the cancer patient first and usually last. He represents our first line of offense. He, above all others, must be made cancer conscious. Invariably, it follows that the close cooperation between the clinic personnel and the practitioner leads to the success of the clinic. By making the general practitioner take an active part in the diagnosis, treatment, and follow-up of the case, better cooperation is obtained from the patient with resultant improvement in end results.

### *Importance of local cancer clinics*

Patients can be treated at decentralized cancer institutes more promptly, more efficiently and less expensively than would be the case if they were required to travel long distances. Modern treatment of cancer usually requires a prolonged, well planned course of treatment. In many cases, this period of active therapy may extend over 6 weeks. One should consider the economic loss if a patient had to travel 50 miles a day for a treatment lasting 10 minutes. If this patient were institutionalized, the daily maintenance cost would far exceed his treatment cost. In most instances, when treatment facilities are in close proximity, the patient is ambulatory and can follow, at least to some extent, his usual line of work, thereby avoiding a total economic loss to his family. Hospitalization could then be reserved for specialized treatments. This disposes of the usual criticism from the hospital staff that the establishment of a local cancer clinic would fill otherwise active beds with chronic invalids. The reverse would be true, for by the earlier diagnosis and proper treatment more cancer patients will be cured, thus leaving fewer to occupy terminal beds.

### *Organization and operation of tumor clinics*

Many inquiries have been received concerning the expense, equipment, organization and operation of tumor clinics. This report will therefore focus on the answers to these questions.

We have in mind three distinct types of tumor clinics:

A. The first is a clinic which functions 6 days a week under constant supervision of a trained oncologist. It treats cancer in all its phases and is organized to offer services to the public. This would, of course, require a hospital set-up which would make possible the examination of private and clinic patients. It would require integrated service in this specialty in the hospital.

B. The second type is a tumor clinic, where the interested physicians on the existing staff play the largest part in the work. It would call for a consultant whose function would be to aid in the organization of the clinic and development of its services. This plan presupposes very active interest on the part of a surgeon, radiologist, and pathologist at the hospital who are willing to devote considerable time to such a department.

C. The third type (which may eventually develop into a full-grown and well-organized complete clinic) is the diagnostic or screening clinic. This could be a department in the regular out-patient clinic of the hospital. It might well be that all tumor clinics should start in this manner so that the staff migh find out whether there is enough interest to warrant expenditures for a tumor clinic.

In many hospitals it will be impossible (and not advisable) to start cancer clinics of the type which have been described under the A and B headings. In every hospital, however, there are several physicians interested in malignant disease. It might be possible under these circumstances to begin what is known today as a diagnostic cancer clinic, to which patients suspected of having cancer may be referred (either directly or indirectly, as may be seen fit) for a complete physical examination, including the necessary laboratory work. This could be arranged on a part-time basis in which physicians receive a portion of the fees so collected. The function of such a clinic is primarily diagnostic. Once diagnosis is made, the patient is referred back to the family physician.

Arrangements should be made with certain institutions for the referral of specific cases from diagnostic clinics, when such referrals are necessary and agreeable to the family physician.

The set-up of a diagnostic clinic has to be individualized to meet the needs of a hospital.

*Cooperation of medical organizations offered*

A recent survey has brought out the fact that although many cancer clinics in this State are well organized and are functioning admirably, many others exist only as paper organizations.

The committee should like to see these clinics improved and attain a status comparable to the average well-functioning clinic, serving the community and reflecting credit on the local profession. Toward this end the cancer-control committee of the Medical Society of New Jersey and the American Cancer Society are prepared to render technical and financial aid to hospitals desiring the establishment of cancer clinics meeting the standards set forth above.

Inquiries should be addressed to Cancer Control Committee of the Medical Society of New Jersey, 315 West State Street, Trenton 8, N. J., or Medical Director, American Cancer Society, 790 Broad Street, Newark 2, N. J.

*Staff organization*

1. Active personnel may consist of 10 persons, as follows: (1) The executive director, who would be the attending surgeon, department of malignant and allied diseases; (2) an associate attending surgeon; (3) an associate radiologist; (4) an assistant attending surgeon; (5) an intern; (6) the pathologist; (7), (8 two dispensary physicians—to permit as many physicians as possible to have contact with this work, the dispensary physicians should be rotated; (9), (10) nurse and secretary.

2. Consulting personnel should consist of an attendant on duty from each of the following departments: (1) Surgery; (2) internal medicine; (3) urology; (4) otolaryngology; (5) gynecology; (6) orthopedics; (7) dermatology; (8) neurology; (9) obstetrics; and (10 dentistry.

Of necessity, this table of organization will not be universally applicable, but it suggests a nucleus around which changes may be made to suit individual needs.

If a part-time oncologist is used, it will be found that after several years the attending staff personnel who have had sufficient time and interest will have acquired considerable knowledge and skill in the management of malignant disease. They, therefore, may assume progressively more authority and more responsibility until the time is reached when it is no longer necessary for the consulting oncologist to spend as much time in the clinic. It is essential, however, that the interest in the clinic be continually stimulated so that the department is always modern in is concepts.

*Suggested rules and regulations*

Following are some of the rules and regulations applicable to cancer clinics:

1. No indigent patient should be admitted directly unless referred from a recognized cancer clinic.

2. Private patients should be admitted directly to the clinic or to physician designated upon written request of the family physician.

3. Physicians referring indigent patients refer them to the dispensary first, and the dispensary physician in the appropriate departments refers the case to the cancer clinic. This rule may be altered to suit variable circumstances.

4. For all private patients, and, so far as is possible, in the case of clinic patients, a written report should be made to the family physician. The report includes diagnosis and recommendations for management of the disease.

5. No treatment on private patients is undertaken without notification to the family physician.

6a. A consultation request should be sent to the cancer clinic on all general service patients suspected of having a malignant disease. It remains at the discretion of the attending physician on service whether the patient is referred to the department of malignant and allied diseases after an opinion is rendered. If surgery is required, the cancer service should have the privilege of assisting.

6b. On all general-service patients admitted to the cancer service, a consultation should be required with the interested service; and in the event of surgery, the department in which that particular type of service falls should have the privilege of assisting. (This is extremely important and requires close cooperation on the part of the staff. It will also improve the quality of cancer work in the hospitals.)

Rules governing the admission of general service patients into the hospital would depend upon whether there was a recognized cancer service in the hospital wards.

*Cost of establishing tumor clinics*

The special tumor clinic may be established for approximately fifteen to twenty thousand dollars. Any material alterations or the building of additional housing units would, of course, increase this estimate. It is possible to establish diagnostic and treatment facilities much more cheaply than this; also much more expensively. We have chosen this estimate because we feel that it covers all the necessities for diagnosis and treatment and has proved completely satisfactory.

Generally speaking, the minimum floor space requirements will vary between 1,000 and 1,200 square feet. The use of two or more examining rooms is especially recommended for busy clinics. The availability of space determines the planning of the rooms.

*Roentgen equipment*

Largest single expense is the 200 to 250-kilovolt X-ray machine and the 100-kilovolt machine, for which, in the aggregate, $8,600 to $10,000 is allowed. If it appears essential to do so, considerable saving may be effected by not installing a separate transmitter for the low-voltage machine. It then becomes necessary to use a high-tension switch in conjunction with the transformers for the high-voltage machine. Objections may be raised against this practice because only one machine may be run at any one time. However when one considers the small number of low-voltage treatments in comparison with the larger number of high voltage-treatments and the space saved by the use of only one treatment room and control panel for all roentgen therapy, the advantages far outweigh the disadvantages, if the latter exist at all.

Supplementary equipment for the X-ray machines is as follows (some of the costs are omitted because they vary considerably):

| | |
|---|---|
| Schreiner adjustable diaphragm<br>(With this diaphragm one is able to obtain practically any desired size square or rectangular portal without the use of special cylinders for each.) | $150 |
| Circular cylinders (cones)—For circular portals. Sizes 10, 9, 8, 7, 6, 5, 4, 3.5, 2.5 centimeters. | |
| Master cylinder for therapy at 50 centimeters T. S. D. | |
| Master cylinder for therapy at 70 centimeters T. S. D. | |
| Intraoral cylinders—Sizes 4, 3.5, 3 centimeters. Used for selected intraoral therapy. | |
| One 14 x 7 cm. rectangular cylinder for esophageal or other specialized treatment at 70 centimeters. | |
| Metal pointers used to center the X-ray beam at the desired area. Since low voltage is operated at 30 and 20 cm. T. S. D. these cylinders are interchangeable on both machines. This avoids the purchase of separate cylinders for the low-voltage machine, thereby affording a considerable saving. | |
| Complete lead lining for therapy room equivalent to the Bureau of Standards recommendation of 5/32 in<br>(This estimate varies according to the amount and type of lead or lead panelling used.) | 1,500 |

Because the modern technic of roentgen therapy for cancer is becoming more exact, we do not believe any economy should be effected by restriction of the accessories mentioned above.

*Radium*

Radium may be purchased at approximately $21.50 per milligram in amounts of 100 milligrams; or rented for $40 per month, the latter covering all insurance (2 percent of value per gram) and all necessary instruments within certain limitations.

The following is the radium outline suitable for a complete clinic:

| | |
|---|---|
| Radium—150 to 250 milligrams—put up in 30 to 50 platinum cells of 11.5 mm. length, 12 mm. wall thickness, 1 mm. external diameter, containing 5 mg. radium | $3,360 to $5,600 |
| 12 special platinum iridium sheath needles, single eyelet, removable point (Treves needle), 17 mm. in length, 1.65 external diameter, and 3 mm. wall thickness | 144.00 |

| | |
|---|---|
| 12 special gold sheath needles with removable platinum iridium trocar points with double eyelets, each for 2-cell over-all length wall thickness 0.3 mm | $105.00 |
| 8 special gold sheath needles as above but holding 4 cells, over-all length | 90.00 |
| 6 standard platinum capsules of 0.8 mm. wall thickness each to contain 5 single cells | 210.00 |
| 1 special platinum capsule of 0.8 mm. wall thickness to hold 8 single cells | 40.00 |
| 3 brass plaques of various sizes (square, long, round) to hold radium for superficial application | 15.00 |
| 1 needle extractor | 2.75 |
| 1 instrument for inserting needles (straight) | 2.75 |
| 1 needle inserting forceps (retro and extra groove made for straight insertion) | 5.00 |
| 1 needle inserting forceps (straight and right-angle grooves) | 5.00 |
| 1 long forceps (for handling cells) | 2.50 |
| 1 rubber tubing | 1.00 |
| 1 special intubating forcep | 7.00 |
| 2 special chuck device for opening platinum capsules and sheath needles | 10.00 |
| 1 special double and point remover (12 inches long) | 2.00 |
| 1 Healy two-way cervical applicator | 18.00 |
| 1 lead storage chest | 150.00 |
| 1 Failla type carrying case | 60.00 |
| 1 lead radium shield | 150.00 |
| 1 combination safe for storage of radium | 50.00 |

Since accurate diagnosis is so important in cancer therapy, proper equipment incident to this is necessary. Instruments listed below may already be available in the hospital, in which case it is usually not necessary to duplicate them, although having the clinic equipped in its own right is more advantageous.

*General equipment*

The following is a list of diagnostic and therapeutic instruments suggested as a full complement:

| | |
|---|---|
| 1 treatment chair with headrest | $16.00 |
| 1 fountain cuspidor (on pedestal) complete with saliva ejector and drinking attachment | 71.00 |
| 1 nose and throat outfit with large, heavy-duty pump instead of small pump (several attachments purposely omitted) | 350.00 |
| 1 bronchoscope sterilizer (25 in.). | |
| 1 small sterilizer (10½ in.). | |
| 1 oesophagoscope medium (Janeway or Jackson type) | 45.00 |
| 1 gastroscope (Janeway type) | 50.00 |
| 1 set United dilating olives | 35.00 |
| 1 Jackson laryngoscope | 17.50 |
| 1 Jackson laryngoscope (anterior commisure) | 20.00 |
| 1 Jackson bronchoscope 204 7 x 40 | 13.50 |
| 1 Jackson bronchoscope 9 x 40 | 13.50 |
| 12 bulbs for laryngoscope and bronchoscope | 12.00 |
| 1 Clerf's atomizer | 8.25 |
| 1 Yankauer glass dropper | 1.50 |
| 2 Jackson cotton carriers | 8.25 |
| 1 head lamp | 15.00 |
| 1 Martin superficial tongue and throat biopsy forceps | 7.50 |
| 1 Martin thin-blade throat scissors | 5.50 |
| 1 Martin universal handle for biopsy tips | 12.50 |
| 1 Martin round biopsy tip for above | 12.50 |
| 1 Martin angulated tip for above | 12.50 |
| 1 canula for above—8-inch straight | 4.50 |
| 1 canula, 12-inch straight | 5.50 |
| 1 canula, 16-inch straight | 6.00 |
| 1 canula, 22-inch straight | 7.00 |
| 1 canula, curved laryngeal | 4.50 |
| 1 biopsy forceps for postnasal work | 27.50 |
| 2 bayonet dressing forceps | 4.00 |
| 1 soft palate retractor | 15.00 |
| 2 tongue depressors (metal) | 4.00 |

| | |
|---|---|
| 6 assorted mirrors | $5.40 |
| 1 Baucheron ear speculum set | 2.25 |
| 1 ring ear curette | 1.50 |
| 1 Martin cheek retractor | 5.50 |
| 1 Jennings' mouth gag | 10.50 |
| 2 nasal speculas | 5.50 |
| 8 tracheal tubes with obturators, Nos' 4, 5, 6 x 3, 7, 8, 9 | 50.00 |
| 2 operating and examining tables | 160.00 |
| 1 Mayo stand | 17.50 |
| 1 instrument and supply cabinet | 120.00 |
| 2 current controllers for diagnostic instruments | 17.00 |
| 2 aspirating biopsy syringes | 15.00 |
| 4 aspiration biopsy needles—2″ | 5.60 |
| 4 aspiration biopsy needles—3″ | 5.60 |
| 2 aspiration biopsy needles—5″ | 3.30 |
| 1 aspiration biopsy needle—9″ | 3.50 |
| 1 Labot type regional syringe | 5.00 |
| 3 Bard-Parker handles No. 3 | 3.00 |
| 1 cautery for A. C. current complete with pistol grip handle, illumination light and assortment of cautery tips | 35.00 |
| 12 mosquito forceps (B. L.) | 60.00 |
| 6 Kelley forceps (B. L.) | 30.00 |
| 2 plastic retractors | 4.00 |
| 4 assorted plastic scissors | 16.00 |
| 2 fixation plastic forceps, without catch | 6.50 |
| 1 Haydeman bone ronguer | 12.00 |
| 1 mastoid retractor | 12.50 |
| 2 needle holders | 10.00 |
| 4 dressing forceps | 10.60 |
| 3 tissue forceps | 6.75 |
| 2 sponge forceps—long | 6.50 |
| 3 M. O. scissors 5½ inches straight | 9.75 |
| 1 curved Mayor scissors 5½-inch | 6.50 |
| 1 bone curette No. 5 | 3.00 |
| 1 bandage scissors 7½-inch | 2.25 |
| 1 Bowles stethoscope | 2.50 |
| 3 stainless steel pus basins 10 inch | 7.50 |
| 1 mercurial sphygmomanometer | 27.50 |
| 2—2 cc. syringes | 2.50 |
| 1—5 cc. syringe | 2.00 |
| 1—10 cc. syringe | 2.50 |
| 1—20 cc. syringe | 3.00 |
| 3 dozen assorted needles | 8.50 |
| 1 small spot lamp | 18.50 |
| 1 endotherm machine (complete) | 300.00 |
| 1 scale | 30.00 |
| 2 waste receptacles | 5.00 |
| Furniture | 600.00 |
| Photographic equipment | 75.00 |
| 1 cystoscopic biopsy forceps | 18.00 |
| 1 cystoscope with convex sheath | 160.00 |
| 1 A. C. M1 battery box unit | 18.50 |
| 1 wall irrigating outfit | 18.50 |
| 1 proctoscope—complete set | 41.50 |
| 1 special proctoscope suction tube | 3.70 |
| 1 Healy cervical biopsy forceps | 10.50 |
| 1 uterine forceps | 3.25 |
| 3 Graves speculum (large, medium, small) | 11.50 |
| 1 plain uterine sound | 1.25 |
| 1 uterine tenaculum forceps | 3.75 |
| 1 Goudel uterine dilator | 12.65 |
| 1 uterine irrigating sound | 1.75 |

This is the first in a series of articles on the cancer program in New Jersey.

[Reprinted from the February 1947 issue of the Journal of the Medical Society of New Jersey, vol. 44, p. 41]

## THE CANCER PROGRAM IN NEW JERSEY

### PART II—A STATE-WIDE TISSUE DIAGNOSTIC SERVICE

Prepared by the Advisory Committee on Cancer Control,[1]
the Medical Society of New Jersey

Early diagnosis is the key to successful management of cancer. Early diagnosis is predicated on the development of a high index of suspicion in conjunction with a thorough history and complete physical examination.

In many instances, where clinical diagnosis is difficult or doubtful, a biopsy is the procedure which removes doubt, leads to and offers the greatest opportunity for the successful treatment of the lesion.

Biopsy—the removal of small portions of suspected tissue for microscopic examination—is a procedure of the greatest value and importance in the cancer control program. The plan outlined here for a State-wide Tissue Diagnostic Service, places at the disposal of every physician in New Jersey a very important aid in his work of cancer diagnosis.

*The general practitioner's opportunity*

General practitioners have the greatest opportunity for discovering early cancer; they see more patients than all the hospital clinics combined.

The biopsy service can be a valuable adjunct to the office practice of every general practitioner and specialist whether they practice in urban or rural areas.

*Follow-up at regular intervals*

Cancer is the great masquerader of the day. It must be suspected before it can be detected. An apparently inocuous small tumor mass today, can change in its pathologic character in a matter of weeks, hence the necessity for follow-up of a patient at regular intervals, with a careful record of the exact size of the mass in terms of centimeters or inches. Do not record it as a "small mass" or even as "mass, the size of a quarter."

It is equally important to impress on the patient the importance of returning for a check-up on a given date rather than giving the admonition to "drop in if it bothers you."

It is obviously far better to have a suspicion of cancer and upon recheck and examination find it groundless, than harbor the suspicion (or worse yet ignore the possibility) until the suspicion has become a certainty and delay may have caused the spread of the disease with consequently increase in the difficulties of treatment.

*Tissue diagnostic services*

The present plan was developed as a result of conferences between representatives of the board of trustees, the Medical Society of New Jersey, and representatives of the other interested agencies.

The plan is predicated on the following agreement:

1. Members of the New Jersey Society of Clinical Pathologists and other recognized pathologists will provide the diagnostic skills.

2. Physicians desiring to avail themselves of this service, will send tissue specimens to the pathologist of their choice. These specimens are to be submitted in containers to be furnished, accompanied by a standard report form giving the necessary clinical data, regarding the patient, the patient's economic status and other pertinent medical and personal information.

Tissue specimens taken by private practioners from their indigent patients attended privately, not in hospital clinics, will be processed and diagnosed gratis. The pathologist's customary fee with be charged all other patients.

"3. This is a voluntary agreement; nothing herein shall be construed to apply to or mean a change in any present tissue diagnostic service in hospitals and clinics, private or public, throughout New Jersey.

"4. The American Cancer Society, New Jersey Division, Inc., will provide the necessary number of containers, suitable for the mailing of tissue specimens by private physicians to pathologists of their choice.

"The specimen containers include the necessary amount of fixative (10 percent formalin); these will be distributed to private physicians throughout the state. The costs of such distribution to physicians will be borne by the American Cancer Society, New Jersey Division, Inc.

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[1] The committee consists of Drs. W. O. Wuester (chairman), O. R. Holters, J. I. Echikson, H. W. Jack, J. H. Kler, T. B. Lee, W. J. Marquis, Leonid S. Snegireff, and Emil Frankel, consultant.

"5. Any system for the reclaiming of containers for further use will be encouraged and, if practicable solution can be arrived at, may come within the scope of activities of the Field Army, American Cancer Society. Since containers cost 22 cents each, they should not be wasted."

According to this plan, all physicians in New Jersey will be circularized by a post card with a prepaid reply card, requesting that they indicate whether they desire to receive biopsy containers, and if so to state whether four or six such containers are desired.

Along with the containers there will be sent a card requiring the physician submitting biopsy specmens to fill in certain basic, pertinent data for the pathologist's information.

The American Cancer Society, New Jersey Division, Inc., has set aside $5,000 for the above project which includes purchase of containers; fixative; handling; mailing and printing costs.

Below is a sample of the instruction sheet and report form.

*New Jersey Society of Clinical Pathologists cooperates*

Recognizing the importance of pathologic diagnosis in the management of cancer cases, the executive committee of the New Jersey Society of Clinical Pathologists adopted recommendations for the establishment of a cooperative program between that Society and the Division of Cancer Control in the State Department of Health at a meeting held in Newark in December 1946. This action of the executive committee was later approved by the members of the society.

## CANCER CONTROL ACTIVITIES

### MEDICAL SOCIETY OF NEW JERSEY AND COOPERATING AGENCIES, TISSUE DIAGNOSTIC SERVICE

All tissue specimens must be put immediately in glass containers furnished, and covered with 10 percent formalin solution supplied in the bottle. Labels on glass container should bear name of patient and attending physician.

The following data is to be furnished on the card:

Patient's full name________________________________________ Date__________
Address________________________________________

Sex________________________ Age________
Brief history with clinical impression

| *Patient Status* | *(Check)* |
|---|---|
| Private | |
| Indigent | |

______________________________________________________________________

Name of Physician taking biopsy

______________________________________________________________________
______________________________________________________________

*Address*

Exact source of specimens (anatomic site)________________________________
Diganosis of pathologist______________________________________________

N. B. This card is for permanent record.

Please fill in all details. If necessary use reverse side for additional data.

________________________________________
*Signature of pathologist*

________________________________________
*Address*

Designed to promote the scientific study of tumor pathology and to augment pathologic diagnostic services to the medical profession, the following recommendations for the joint program were adopted:

1. That the Society of Clinical Pathologists establish a tumor registry in cooperation with the Division of Cancer Control of the New Jersey Department of Health.
2. That such a tumor registry offer physical facilities for the collection and filing of cancer case histories, tissue slides, gross pathologic specimens and photographs of pathologic material; that it maintain library facilities, and keep other pertinent data related to tumor problems.
3. That cancer histories, tissue slides, and other data necessary for the maintenance of the registry be furnished by the members of the Society of Clinical Pathologists and other physicians, for permanent filing with the registry.
4. That the Division of Cancer Control of the State Health Department provide laboratory facilities for the preparation of gross pathologic specimens and microscopic sections for the tumor registry.

5. That the Division of Cancer Control of the State Health Department employ a competent pathologist (approved by the consulting board of the tumor registry) whose activities will be guided by the consulting board insofar as the work of the tumor registry is concerned.

6. That the Society of Clinical Pathologists select a consulting board of tissue pathologists to direct the professional activities of the tumor registry in cooperation with the Division of Cancer Control, State Health Department.

7. That the chief of the Division of Cancer Control of the State Health Department be a member of the consulting board of the Society of Clinical Pathologists.

In order that the reader might have the benefit of the best thoughts on the subject of biopsy, detailed authoritative opinions are cited below.

*Is biopsy a dangerous procedure?*

Biopsy has often been avoided because of the fear that the procedure itself might awaken a relatively quiescent growth to increased and undesirable activity. Theoretically this is a reasonable assumption but practical experience shows conclusively that this possibility may be largely discounted and should not be the sole deciding factor governing the decision to take a biopsy. Even if such a possibility could be regarded as imminent, its implications may be eliminated in large measure by methods permitting the immediate examination of the removed tissue, concerning which more will be said later. The fear of increasing the activity of a malignant growth through biopsy should not be considered a contraindication, nor lead to neglect of this most important and valuable means of early diagnosis of cancer.

To this general rule there is, however, one proper exception, namely, sarcoma. As sarcomata are frequently highly vascular, and as they metastasize mainly by way of the blood stream, any procedure which tends to injure, disturb, or open up blood channels obviously increases the opportunity for metastasis and may even initiate such dissemination of the tumor by way of the circulation. This is particularly true of melanotic sarcoma which, because of its extraordinary tendency to explosive and fulminating metastasis, should never be subjected to biopsy.

The status of biopsy, in relation to its theoretical dangers, has been succinctly put by Eric Liljencrantz, M. D., in the Standford University Cancer Handbook:[2]

"1. Whatever the theoretical dangers of biopsy may be, the dangers of attempting radical treatment of or abandoning a patient to a hopeless prognosis without tissue proof are far more serious.

"2. The dangers of biopsy and the time elapsing before starting treatment vary widely for various tumors. Tumors of breast, bone, and thyroid should not be cut into or narrowly excised unless all preparations are made for examination of quick-frozen sections and immediate radical operation.

"3. Biopsy of tumors of skin, lip, oropharynx, bladder, and uterus is less dangerous; but the minimum of time (a few days perhaps) should elapse before institution of treatment. Melanoma should never be cut into."

Properly performed biopsy is less dangerous than is rough handling or massage by patient or physician.

If fractionated courses of X-ray treatment are contemplated in treatment, biopsy may be taken after such treatment is well under way.

It must be recognized, however, that the effect of radiation, and especially of repeated radiation, upon tissue may definitely complicate, if it does not obscure, the interpretation of the microscopic picture and to this extent increase the difficulty of microscopic diagnosis.

Neither indiscriminate biopsy nor indiscriminate radiation before biopsy can be commended without reserve. Both should be safeguarded by sound clinical judgment and, not infrequently, the combined judgment of all concerned.

A biopsy should be done whenever the slightest suspicion of malignant disease exists.

It should be remembered that any indolent lesion, reluctant to heal, particularly when located in regions frequently subject to cancerous disease (cervix, mouth, lips, etc.), and any "lump" in a breast, are all open to the suspicion that they may be malignant and if they are, the sooner this is known the better. It is not the suspicion of cancer which is to be feared but the careless optimism which denies or ignores the suspicion until it may be too late. As a general principle it may be said that the outlook for the successful treatment of cancer is best when the difficulties of diagnosis are greatest. Hence, the value of biopsy examinations. But it should also be emphasized that biopsy is only one of the phases of examination of the patient suspected of having a cancer and should not be relied upon to the neglect of a simultaneous thorough clinical study.

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[2] Cancer Handbook, Stanford University, p. 13.

Valuable as a biopsy may be it should never be decided upon without a careful consideration of all the factors involved and an appreciation of its limitations and possible dangers, and the final decision should always be governed by good clinical judgment and experience.

### *Other values of biopsy*

Primarily, biopsy is a diagnostic procedure, but it also has other uses. For example, it may be used to determine the degree of malignancy as based upon the microscopic picture, and thus to form grounds for clinical prognosis or substantiate a prognosis already given. For, while the clinical picture may well justify a grave, if not hopeless, prognosis, either the patient or his relatives may be reluctant—and naturally so—to accept it without microscopic proof.

Biopsy may also be used as a partial criterion of the sensitivity of a cancer to radiation and hence as a criterion of the possibility of the successful use of such therapy.

### *Microscopic diagnosis*

The microscopic diagnosis of cancer must necessarily be based upon numerous factors of varying significance. Among these are: The character and appearance of the cells; the nature and degree of their variations from normal, their groupings and, particularly, their relation to the adjacent normal tissues.

One of the predominant features of a malignant growth is its ability to invade contiguous normal tissue. This, however, can be determined only when some of the adjacent normal tissue is included in the tissue examined. It is thus readily apparent that the information obtainable from the microscopic study of biopsy tissue is in definite proportion to the care and skill with which the specimen has been obtained.

For example, a suspicious lesion may appear as a crateriform ulcer, secondarily infected with a control area of necrosis covered, perhaps, with a firm scab of dried exudate.

Obviously, the removal of the scab for microscopic examination will be useless, for little or nothing will be seen of the changes upon which the diagnosis of cancer depends.

It is equally clear that removal of necrotic tissue will also produce a tissue specimen of little or no value for microscopic study. In such case the biopsy specimen should be wedge-shaped and include the margin of the ulcer.

When there is clinical uncertainty whether or not a biopsy should be done, or from what portion of the lesion it should be taken, it is both wise and profitable to consult with the pathologist who will have to study the tissue.

### *Aspiration biopsy*

Since 1930, when the technic of aspiration biopsy was first described by Martin and Ellis, it has attained widespread use in ever increasing fields. It is indicated for tumors lying beneath the surface when it is desired to avoid an incision. Properly performed, it has been a success. It avoids the objection of performing surgical biopsies through normal tissues. It is the most rapid of all biopsy procedures. The procedure, staining of the slide, and interpretations, can be done in 15 minutes. Operations may frequently be avoided as in the case of breast cysts where simple aspiration usually suffices.[3]

### *How should a biopsy be taken?*

Various methods are available for the removal of biopsy specimens. They may be excised with the scalpel cutting current of cautery or radioknife; "punched out" by various devices; secured by curettage; aspirated with needle and syringe; or, in the case of fluids, removed by needle and syringe or trocar.

Which is the most suitable method depends upon the nature and location of the lesion, its predominant clinical manifestations, and the clinical situation in general. The important thing is not how the specimen is secured but how suitable is it for microscopic study?

It is sometimes thought that biopsy excisions of tissue should always be done with the cautery or radioknife because lymph channels are thereby sealed off. It must be remembered, however, that the inevitable tissue coagulation which results materially interferes with microscopic study and may render it inconclusive unless the excision has been relatively wide of the lesion.

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[3] For the complete description of the aspiration biopsy the reader is referred to the original article by Martin and Ellis, Journal of Surgery, Gynecology and Obstetrics, 1930.

*The pie-cut technic*

One of the most acceptable methods of biopsy is the pie-cut technic, used in ulcerating lesion; this may be illustrated in the following steps:

1. Choose your site well (see figs. 1 and 2).
2. Include some of the ulcer base edge and surrounding tissue.
3. Grasp edge lightly with forceps and raise up while undermining with knife (see fig. 3).
4. When cautery is used employ cutting current and clean loop to insure minimum of charring.
5. A biopsy forceps is excellent for cervical lesions. This is an office procedure and is easily done.

*The good specimen*

It is already obvious that size is not the sole (nor the best) criterion of a good biopsy specimen. Quality not quantity is the determining factor. The diagnosis of cancer may be clear-cut and final from a very small tissue fragment properly chosen, and doubtful or inconclusive from a relatively large mass poorly selected. It cannot be too strongly emphasized that while a positive diagnosis of cancer from a small piece of tissue is final and absolute, a negative diagnosis from small tissue fragments is not necessarily as equally conclusive and should be corroborated by examination of a second biopsy.

When the lesion is small its total excision is preferable. This is often spoken of as a "therapeutic biopsy" because of the complete removal of the lesion.

By rapid frozen-section biopsy is meant the preparations of the tissue immediately after its removal so that it can be examined microscopically at once. The obvious advantage is that the interval between biopsy and operatively removal of the tumor is reduced to minutes.

Rapid biopsy is advantageous when (1) all proper technical facilities are at hand; (2) when the necessary skill in interpreting such specially stained sections is available.

However, it should not be considered the invariable method of choice to be resorted to under any and all circumstances, for this method has certain important and inherent disadvantages.

First and foremost is the fact that the tissue pathologist who must make the important decision is forced to work under the definite demand for speed, speed, and more speed.

Five or 10 minutes is a short time ordinarily, but to the surgeon, standing over an anesthetized patient with poised scalpel, it may seem an age. If the microscopic picture seen by the pathologist is definitely that of cancer, all is clear. But if, as it may be, it is indefinite and dubious and more sections are desirable, clear judgment and calm appraisal are difficult in the face of repeated and insistent demands for a report.

More than once has every tissue pathologist found nothing in the rapid sections upon which to base a diagnosis of cancer only to see such evidence clearly in subsequent paraffin sections prepared from the same block and studied carefully and without haste or turmoil.

Recently many pathologists have transected specimens removed in operating room for rapid study, and wiped some of the cells from the surface to form a thin smear which rapidly dries. This can be quickly stained as in the aspiration biopsy technic. Results are often better than with frozen sections.

With the development of the methods at present available, for the relatively rapid preparation of well-cut and well-stained paraffin sections, the importance of and necessity for rapid-frozen-section technic becomes less and less.

Whenever a rapid-tissue technic is desired the pathologist should always be notified in ample time to make all necessary arrangements.

*How should biopsy specimens be sent to the pathologist?*

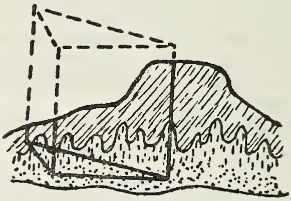
Biopsy tissue should be placed in 10 percent formalin (one part formalin to nine parts water) immediately upon removal and may remain in this fixative indefinitely.

The container furnished is large enough to allow the easy housing of the specimen.

Biopsy tissue should never be allowed to become dry and hardened; in the case of fluids or curetting, specimens should never be taken upon a swab, soaked

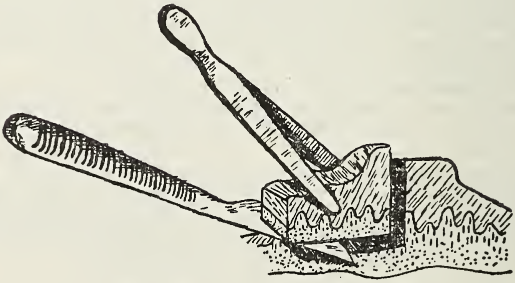
(1)

Biopsy Technic



(2)

Biopsy Technic



(3)

Biopsy Technic

up on cotton, or enmeshed in gauze, from all of which the specimen can be removed only with difficulty, loss, or damage.

*What information should accompany the biopsy specimen?*

It should be appreciated that the tissue pathologist is functioning essentially as a consultant and, as such, deserves the same courtesy afforded any other consultant. It is always well—and may sometimes be of the greatest value—for him to know the location of the lesion, its gross characteristics, its duration, predominant clinical characterists and symptoms, the age and sex of the patient.

While the tissue itself may present a microscopic picture so clear-cut and definitive as to be conclusive per se, in the doubtful case the clinical data may assume great importance. It is important therefore that the card accompanying the biopsy specimen be completely filled in.

The classic axiom of Osler in reference to another disease may well be paraphrased:

Be quick to suspect cancer but slow to diagnose it and corroborate the diagnosis by all available means.

*Atlantic County approved project*

| | |
|---|---|
| For the improvement of services through the Atlantic City Hospital to cancer patients in Atlantic County: | |
| Personnel | $2,400 |
| Permanent equipment | 10,500 |
| Total | 12,900 |

*Burlington County approved project*

| | |
|---|---|
| For the improvement of services through the Burlington County Hospital and Zurbrugg Memorial Hospital: | |
| Personnel | $3,000.00 |
| Permanent equipment: | |
| Burlington County Hospital | 3,086.00 |
| Zurbrugg Memorial Hospital | 687.75 |
| Consumable supplies | 600.00 |
| Total | 7,373.75 |

*Bergen County approved project*

| | | | |
|---|---|---|---|
| Bergen County medical project: | | | |
| County-wide gold radon seed pool for indigent cancer patients to to be administered by Bergen County Medical Society Cancer Committee | | | $1,000.00 |
| Fund for bedside nursing of indigent cancer patients in Bergen County through subsidy on per patient visit by existing visiting nursing organizations in the county not to exceed the rate of $1.40 per patient visit | | | 2,000.00 |
| Englewood Hospital: | | | |
| Permanent equipment | $2,796.80 | | |
| Personnel | 2,100.00 | | |
| | | $4,896.80 | |
| Hackensack Hospital: | | | |
| Permanent equipment | $4,445.50 | | |
| Personnel | 1,700.00 | | |
| | | 6,145.50 | |
| Consumable supplies | | 3,365.00 | |
| | | | 14,407.30 |
| Bergen County Chapter Service and Education Committee's budget: | | | |
| Personnel | | $3,500.00 | |
| Permanent equipment | | 535.00 | |
| Operating expense | | 1,700.00 | |
| | | | 5,735.00 |

*Bergen County approved project*—Continued

| | |
|---|---|
| Bergen County medical project—Continued | |
| Medical equipment for Englewood Hospital tumor conference: | |
| Permanent equipment | $1,235.00 |
| Total for Bergen County | 24,377.30 |

*Camden County approved project*

| | |
|---|---|
| County-wide cancer control project for Camden County, N. J., including improvement of services and equipment in cancer clinics at the Cooper and West Jersey Hospitals in the city of Camden: | |
| Personnel | $7,340.00 |
| Permanent equipment | 2,450.00 |
| Consumable supplies | 2,400.00 |
| Operating expenses | 1,200.00 |
| Total | 13,390.00 |

*Essex County approved project*

| | |
|---|---|
| Newark City Hospital: Permanent equipment | $10,795.00 |
| Supplemental: | |
| Personnel | 1,500.00 |
| Permanent equipment | 160.75 |
| Supplemental: Permanent equipment | 415.25 |
| Total | 12,871.00 |
| Beth Israel Hopital: | |
| To improve present facilities and services for the care of cancer patients in the cancer clinic at the hospital: | |
| Personnel | 1,800.00 |
| Permanent equipment | 10,250.00 |
| Consumable supplies | 1,220.00 |
| Total | 13,270.00 |
| Supplemental: Permanent equipment | 1,927.00 |
| Total | 15,197.00 |
| St. Barnabas Hospital: | |
| To improve present facilities and services for the care of cancer patients in the cancer clinic at the hospital: | |
| Personnel | 2,500.00 |
| Permanent equipment | 10,750.00 |
| Consumable supplies | 4,480.00 |
| Total | 17,730.00 |
| St. Michael's Hospital: | |
| Personnel | 2,340.00 |
| Permanent equipment | 11,318.00 |
| Total | 13,658.00 |

*Essex County Gold Radon Seed Project*

| | |
|---|---|
| To improve facilities for treatment of cancer patients within the county by creating a pool of gold radon seeds to be administered under the supervision of the advisory cancer committee of the Essex County Medical Society | $2,000.00 |
| Total for Essex County | 61,456.00 |

### *Essex County Gold Radon Seed Project*—Continued

| | |
|---|---|
| Educational committee project for Essex County: | |
| Personnel | $250.00 |
| Permanent equipment | 535.00 |
| Consumable supplies | 700.00 |
| Operating expense | 250.00 |
| Total | 1,735.00 |

| | |
|---|---|
| Service committee project for Essex County: | |
| Personnel | 3.000.00 |
| Permanent equipment | 662.00 |
| Operating expense | 250.00 |
| Consumable supplies | 2,075.00 |
| Total | 5,987.00 |

| | |
|---|---|
| Lutheran Memorial Hospital of Newark, cancer diagnostic clinic: | |
| Permanent equipment | 831.20 |

| | |
|---|---|
| Orange Memorial Hospital Cancer Clinic: | |
| Personnel | 1,318.00 |
| Permanent equipment | 11,836.35 |
| Total | 13,154.35 |

### *Gloucester County approved project*

| | |
|---|---|
| Gloucester County cancer control project to be administered by the cancer advisory committee, Gloucester County Medical Society: | |
| Personnel | $2,000.00 |
| Permanent equipment | 1,120.00 |
| Consumable supplies | 2,300.00 |
| Total | 5,420.00 |

### *Hudson County approved project*

| | | |
|---|---|---|
| Jersey City Medical Center: | | |
| Personnel | $5,600.00 | |
| Permanent equipment | 940.60 | |
| Consumable supplies | 400.00 | |
| | | $6,940.60 |
| North Hudson Hospital: Permanent equipment | | 4,887.35 |
| Christ Hospital: Permanent equipment | | 8,172.70 |
| St. Mary's Hospital: This is a provisional budget set up pending official notification from hospital staff of installation and operation of a diagnostic clinic (will cover general equipment) | | 2,040.85 |
| St. Francis Hospital: This is a provisional budget set up pending official notification from hospital staff of installation and operation of a diagnostic clinic (will cover general equipment) | | 2,040.85 |
| Bayonne Hospital: This is a provisional budget set up pending official notification from hospital staff of installation and operation of a diagnostic clinic (will cover general equipment) | | 2,040.85 |
| Total for Hudson County | | 26,123.20 |

### *Hunterdon County approved project*

| | |
|---|---|
| Nursing services in cancer patient survey, treatment and education—county-wide project for indigent cancer patients covering costs of: | |
| Nursing services | $700.00 |
| Diagnosis, treatment | 1,800.00 |
| Transportation | 400.00 |
| Operating expense | 654.06 |
| Field army | 500.00 |
| Total | 4,054.06 |

### *Mercer County approved project*

County-wide cancer-control program for Mercer County, including establishment of 4 cancer diagnostic clinics at Mercer, McKinley, and St. Francis Hospitals in Trenton and at the Princeton Hospital at Princeton, N. J. Each clinic to correspond to the "C-type" clinic advocated in the New Jersey program, to improve cancer-treatment facilities at the McKinley Hospital in Trenton:

| | |
|---|---|
| Personnel | $5, 180 |
| Permanent equipment | 7, 375 |
| Operating expense | 1, 000 |
| Total | 13, 555 |

### *Mercer County approved project*

| | |
|---|---|
| McKinley Hospital Cancer Clinic: Permanent equipment | $3, 222. 50 |
| St. Francis Hospital, Cancer Clinic: Permanent equipment | 1, 055. 00 |
| Mercer County Hospital Cancer Clinic: Permanent equipment | 1, 105. 90 |

### *Monmouth County approved project*

| | |
|---|---|
| Monmouth Memorial Hospital: | |
| Personnel | $1, 800. 00 |
| Permanent equipment | 17, 255. 00 |
| Total | 19, 055. 00 |
| Less amount received from Monmouth County chapter July 1, 1946 | 6, 000. 00 |
| Total | 13, 055. 00 |
| Fitkin Memorial Hospital: | |
| Personnel | 1, 800. 00 |
| Permanent equipment | 9, 127. 75 |
| Miscellaneous | 20. 00 |
| Total | 10, 947. 75 |
| For the purchase of radon seeds and equipment relating thereto, for the use of indigent cancer patients in Monmouth County | 500. 00 |
| Employment of a general secretary and social-service worker for a period of 1 year. This amount is to be used for salaries, office space, telephone, traveling expense, stamps, stationery, and so forth. The services of the above will not only be used for the purposes indicated, but to assist in campaign activities, to coordinate various activities relating to cancer in this country | 4, 000. 00 |
| Total for Monmouth County | 28, 502. 75 |

### *Morris County approved project*

To purchase a Ford 8-cylinder station wagon for purpose of the use of the Morris County Chapter, American Cancer Society, for medical, educational and promotional purposes:

| | |
|---|---|
| Station wagon | $1, 679. 51 |
| License | 15. 00 |
| Insurance | 37. 50 |
| Total | 1, 732. 06 |

The hiring of a medical secretary for tumor clinic at Morristown Memorial Hospital:

| | |
|---|---|
| Personnel | 336. 00 |
| Permanent equipment | 343. 50 |
| Total | 679. 50 |
| Total for Morris County | 2, 411. 56 |

*Ocean County approved project*

| | |
|---|---|
| 1. Education | $545.61 |
| 2. Provide facilities for examination of suspected malignant tissues, and local X-ray examinations | |
| 3. To provide radium treatment for indigent cases | |
| 4. Humane care of cancer cases | |
| 5. Clinical examination of suspected cancer cases | |
| 1. Education | 2,120.23 |
| 2. Provide facilities for X-ray examinations | |
| 3. Humane care of cancer cases | |
| 4. Provide radium treatment for indigent cases | |
| 5. Clinical examination of suspected cancer cases | |
| 6. Cooperative consultant service for diagnosis and treatment of cancer patients | |
| Total for Ocean County | 2,665.84 |

*Sussex County approved project*

| | |
|---|---|
| County-wide cancer control program for Sussex County: | |
| Permanent equipment | $2,000.00 |
| Consumable supplies | 500.00 |
| Education and service | 500.00 |
| Operating expense | 200.00 |
| Total for Sussex County | 3,200.00 |

*Passaic County approved project*

| | | |
|---|---|---|
| For general use in Passaic County (nursing care, instruments, radium and radon, special medications, and emergency needs and general office expenses): | | |
| Personnel | | $6,500.00 |
| Permanent equipment | | 5,650.00 |
| Consumable supplies | | 11,000.00 |
| Operating expense | | 1,500.00 |
| Total | | 24,650.00 |
| To aid Tumor Clinic, Paterson General Hospital, Paterson, N. J., for the early diagnosis and treatment of cancer: | | |
| Permanent equipment | | 4,678.00 |
| To aid Tumor Clinic, St. Joseph Hospital, Paterson, N. J., for the early diagnosis and early treatment of cancer: | | |
| Permanent equipment | | 14,080.00 |
| To aid Tumor Clinic, Barnert Memorial Hospital, Paterson, N. J., for the early diagnosis and early treatment of cancer: | | |
| Permanent equipment | $3,205.00 | |
| Consumable supplies | 18.00 | |
| | | 3,223.00 |
| To aid Tumor Clinic, Passaic General Hospital, Passaic, N. J., for the early diagnosis and early treatment of cancer | | 6,835.00 |
| Total for Passaic County | | 53,466.00 |

*Union County approved project*

| | | |
|---|---|---|
| Gold radon seed pool for indigent patients, to be administered by cancer advisory committee, Union County Medical Society | | $1,500.00 |
| Service project for Union County Office: | | |
| Personnel | $2,340.00 | |
| Consumable supplies | 200.00 | |
| Operating expense | 1,725.00 | |
| | | 4,265.00 |
| J. S. Green Cancer Clinic, Elizabeth General Hospital: | | |
| Permanent equipment | $8,933.05 | |
| Personnel | 500.00 | |
| | | 9,433.05 |

*Union County approved project*—Continued

| | |
|---|---|
| Union County project for the improvement of bedside care of cancer patients cared for at home | $2,000.00 |
| Total for Union County | 17,198.05 |

*Warren County approved project*

1. To educate the people of Warren County on cancer.
2. To provide diagnostic and therapeutic clinic at Warren Hospital.
3. To purchase 50 mgm. radium and necessary instruments.
4. To provide secretarial and nursing help at the clinic.
5. For expendable supplies and incidentals for the clinic.

| | |
|---|---|
| Personnel | $100.00 |
| Permanent equipment | 1,300.00 |
| Consumable supplies | 200.00 |
| Operating expense | 200.00 |
| Total for Warren County | 1,800.00 |

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### LIST OF CANCER CLINICS CONDUCTED BY GENERAL HOSPITALS IN NEW JERSEY

Atlantic: Atlantic City, Atalantic City Hospital, biweekly, Thursday, 4:30–5:30 p. m.

Bergen: Englewood, Englewood Hospital, weekly, Monday, 4–5:30 p. m.; Hackensack, Hackensack Hospital, weekly, Monday, 8 a. m. on.

Burlington: Mount Holly, Burlington County Hospital, biweekly, first and third Tuesdays, 3:30–4:30 p. m.

Camden: Camden, Cooper Hospital, weekly, Wednesday, 11 a. m. on; West Jersey Hospital, weekly, Thursday, 12:30–2 p. m.

Essex: Irvington, Irvington General Hospital (by appointment only); Montclair, Mountainside Hospital, weekly, Saturday, 10 a. m. to 12 m.; Newark, Newark City Hospital, 4 days (Tuesday, Wednesday, Friday, and Saturday), 10 a. m. to 12 m.; St. Michael's Hospital, weekly, Thursday (for women) (by appointment for men), 9–11 a. m.; Bethe Israel Hospital, semiweekly, Monday and Thursday, 10 a. m.–12 m.; St. Barnabas Hospital, weekly, Wednesday, 11 a. m. on; Orange, Orange Memorial Hospital (Metcalf Foundation) by appointment.

Gloucester: Woodbury, Underwood Hospital, by appointment.

Hudson: Jersey City, Christ Hospital, weekly, Thursday, 9–10 a. m.; Medical Center, semiweekly, Tuesday and Saturday, 9 a. m.; Weehawken, North Hudson Hospital, by appointment.

Mercer: Trenton, Mercer Hospital, weekly, Tuesday, 11:30 a. m.–12:30 p. m.; McKinley Hospital, weekly, by appointment; St. Francis Hospital, weekly, by appointment.

Monmouth: Long Branch, Monmouth Memorial Hospital, weekly, Tuesday, 12 m.–2 p. m.; Asbury Park, Fitkin Memorial Hospital, weekly, Monday, 10 a. m.

Middlesex: New Brunswick, Middlesex General Hospital, weekly, Thursday, 10 a. m.–12 m.

Passaic: Passaic, Passaic General Hospital, weekly, Monday, 4–5 p. m.; Paterson, Paterson General Hospital, triweekly, Monday, Wednesday, and Saturday, 9 a. m.–12 m.; St. Joseph's Hospital, weekly, Friday, 11 a. m.–12 m.; Barnert Memorial Hospital, weekly, Wednesday, 3:30 p. m.

Union: Elizabeth, Elizabeth General Hospital, daily except Sunday, 8 a. m.–5 p. m., Saturday, 8 a. m.–1 p. m.

Warren: Phillipsburg, Warren Hospital, monthly, third Tuesday, 3–5 p. m.

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[From the Congressional Record]

### EXTENSION OF REMARKS OF HON. CHAPMAN REVERCOMB, OF WEST VIRGINIA, IN THE SENATE OF THE UNITED STATES, FRIDAY, FEBRUARY 28, 1947

Mr. REVERCOMB. Mr. President, I ask unanimous consent to have printed in the Appendix of the Record a very able address on the subject How New Jersey Raises Funds and Fights Cancer, delivered by George E. Stringfellow, president of the New Jersey division of the American Cancer Society and member of the board of directors and the executive committee of the American Cancer Society, at the national campaign meeting, Coronado Hotel, St. Louis, Mo., February 7, 1947.

There being no objection, the address was ordered to be printed in the Record, as follows:

"In organizing for the battle against cancer, we recognize that the lives of thousands of our citizens depended on what we did and how we did it.

"We were faced with an increasing death rate from cancer.

"Our job was to devise and set up a program that would coordinate the thinking and action of the people of the State into a well-geared unit of human machinery; one that would function smoothly, effectively and with determination to achieve the objective—find the cause and then the cure of cancer.

"Any structure we built, if it was to remain permanent, must be erected on the four cardinal pillars of management which are: Plan, organize, delegate, and supervise.

"We planed to organize local chapters, self-governing, within the limitations prescribed by our National and State constitutions, bylaws, policies, and regulations. We planned each chapter would write its own bylaws, elect its own officers and board of managers and also to elect one lay and one medical delegate to the State board of trustees. The State board was to be the policy making body for the State division. Every county therefore would have an equal voice in the decisions.

"Laymen were to be responsible for raising funds and for the business administration of the chapters' affairs. The medical profession would devise and prepare projects for the expenditure of funds. Laymen would be presidents, secretaries, treasurers and chairmen of the finance, campaign, publicity, and education committees. Medical officers would control the local and State, medical and service committees. The chairman of the chapter executive committee would be a medical doctor. The cancer advisory committee of the County Medical Society would be the medical committee of the county chapter.

"We realized that the only way to avoid misunderstanding is to have a definite understanding at the outset, so that the laymen and the medical men will not consciously trespass on each other's responsibility and authority. Very often, the laymen and the medical men speak a different language, but they usually talk about the same things. Those who criticize the medical men when they oppose certain projects, in effect, promote socialized medicine. In such cases, I support the medical men for I am as much opposed to socialized medicine as I am socialized industry. With our cooperative plan decided upon and approved, both by the laymen and the State medical society, whose cooperation was pledged, we proceeded with our planning and organization.

"We also discussed our plans with newspaper editors and publishers and radio people. Their approval and willingness to cooperate was quickly assured. We were now ready to organize.

"Because no chapter had been organized to spend money for medical and service or educational projects prior to the Nation-wide appeal for funds in April 1946, our early efforts at organization were developed mainly for campaign purposes. By April 1, 1946, we had organized fund-raising units in 17 of the State's 21 counties.

"Great care was used in selecting the volunteer supervisory personnel of these groups. Each person chosen for participation in the campaign was eager to work and enthusiastic over the program.

"This interest was clearly reflected in the results of our organized appeal. Against a quota of $471,600 assigned to New Jersey, the amount contributed by the people in the 17 out of 21 counties of our State, was $716,904.

"New Jersey, although ninth in wealth among the States, was third in total funds raised per State; although ninth in wealth, New Jersey was first in funds raised per million dollars of her wealth; although sixth in income per capita, New Jersey was first in funds raised per capita.

"At this point, I want to say a word about the field army. For many years this noble group of women has given outstanding service to the American Cancer Society. In the development, first, of our campaign units in the counties, and later in the development of the service and education committees of the chapters, the field army, now an integral part of the State and local organizations, has continued its fine service to humanity. The cancer-control program owes much to the field army.

"With the fund-raising campaign over, we turned to organization of county chapters. By the end of September 1946 each of the 17 counties organized for the April campaign had formed chapters. The four remaining were organized later—two in December and two in January of this year. Every one of our 21 counties in New Jersey now has a chapter of the New Jersey division.

"Since the formation of our chapters, their medical committees have lost no time in developing projects for the expenditures of funds contributed by the public for the control of cancer.

"With the guidance of our medical director and the approval of the medical men at county and State levels, medical projects have been fully approved in 30 hospitals of 11 counties. Funds totaling $221,339.62 have been made available for these clinic projects. The funds will be expended for purchase of deep X-ray therapy machines, radium, gold radon seeds which are being established in county-wide pools, instruments, and other equipment needed by the clinics for diagnosis and treatment of cancer, for payment for service of medical secretaries, nurse follow-up workers, and technicians in the clinics and in certain areas to stimulate and improve bedside nursing care in the homes of cancer patients.

"We also have set up a State-wide tissue diagnostic service. Through our statistical research program we are providing vital information on cancer mortality and incidence to the medical profession, welfare agencies, hospitals, and the lay public.

"Other county projects now are being considered. Before the end of our fiscal year, August 31, 1947, it is anticipated that all of the available funds from the 1946 campaign will have been expended or earmarked for expenditure.

"We are now organizing for our campaign appeal which is less than 3 months away. One general meeting of chapter presidents, campaign managers, and publicity chairmen from each county was held last November. At that time our complete campaign plans, which had been prepared in advance for their consideration, were discussed.

"Three regional precampaign meetings for final review of campaign plans have been scheduled in different parts of the State. The first, for the northern counties, was held in Newark on Wednesday night. The second will be in Trenton on February 11 and the third in Camden on February 18.

"One of the points I have emphasized to all of our workers is the necessity for conducting our business and our plans for the expenditure of public contributions in a manner that I call operating in a goldfish bowl. I insist that the affairs of the society be conducted in a manner that would reflect to our credit if everything we do should appear on the front pages of the press of the State and over all of our radio stations. The public contributes the money. Therefore the public is entitled to know what is done with it, down to the last penny.

"For this reason I have asked that before the campaign each county make public the purposes for which the 1946 contributions have been used and, at the same time, present a budget for expenditures in 1947 and 1948 on the basis of which they propose to solicit contributions in April. That is keeping faith, and it is only by keeping faith that public confidence and support can be retained and expanded.

"As a means of coordination and supervision of the machinery we have built in New Jersey for the control of cancer, there has been set up at State level a service department. That unit takes the place of what is generally known as a State headquarters staff, and to its personnel and to the volunteer personnel of the chapter has been delegated the authority to act.

"The department is exactly what the name indicates it to be—a service department. The time and skill of its personnel is at all times at the service of each of the State's 21 county chapters, the medical profession, the cancer patients, and the general public.

"Comprising this service department are a manager, who in our State also serves as director of public relations and publicity; a medical director, who acts as liaison between the medical profession and the laymen and guides in formation of cancer projects; a State field army commander, who guides the field army activities throughout the State; and a field director, who supervises organizational activities and is State campaign manager.

"In addition, we have retained the services of a statistical research consultant, who is directing this important phase of our program. We also retain a certified public accountant, who advises us on financial procedures and supervises the accounting—all of which is done by our central office. County funds are restricted for use in the counties in which they are collected, and disbursements are made by the central office upon approval by the county chapter and the State division officers.

"Thus, we carry out the four principles of management—plan, organize, delegate, and supervise.

"With a sound plan—a cause as worthy as ours is—we had little difficulty in attracting the type of men and women needed for a successful program. We then delegated authority to them and the matter of supervision was relatively unimportant. To an organization of high-type citizens willing and accustomed to discharge responsibility has been delegated the authority to act in our great movement, and so a reasonable amount of success has attended our first year of organized effort.

"It has been a great pleasure to be with you today and I am most appreciative for the privilege of discussing with you the manner in which we organized and how we function in the New Jersey division of the American Cancer Society."

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## EXTENSION OF REMARKS OF HON. CHAPMAN REVERCOMB, OF WEST VIRGINIA, IN THE SENATE OF THE UNITED STATES, FRIDAY, FEBRUARY 28, 1947

Mr. REVERCOMB. Mr. President, I ask unanimous consent to have printed in the Appendix of the Record an editorial entitled "A Jersey Adventure," dealing with the subject of cancer, published in the Newark (N. J.) Star-Ledger of February 16, 1947.

There being no objection, the editorial was ordered to be printed in the Record, as follows:

### "A JERSEY ADVENTURE

"What can be done about cancer? Can it be held in check? Is it curable? Is it preventable?

"The question can be answered hopefully but not complacently. Much effort has been made and much reward has been gained. Results have been good enough to warrant the greatest concentration of effort, and incomplete enough to demand further concentration of effort.

"The public has become vaguely familiar with an annual drive for funds by the American Cancer Society. Is that effort worth while? It should be examined critically.

"The cancer campaign does not come in the form of a slot machine into which the public pours contributions for the purpose of extracting standard packages of cancer progress.

"The problem is relatively unexplored, and the work of the American Cancer Society is in the nature of a great movement in which laymen and scientists join forces in an organized manner to make the most effective possible use of existing knowledge and facilities while research continues.

"The fight against cancer has something of the drama and the philosophy of of our wartime crusade for atomic energy. In both instances men and women by the scores of thousands, individually incapable of the necessary accomplishment, are achieving wonders almost beyond their imaginations. The only difference is that the secrecy of the search for atomic energy becomes a publicized process in the search for an answer to cancer.

"It is an actual fact, however, that a clubwoman or businessman can without troubling his lay mind with scientific perplexities contribute knowledge to the great campaign of research against cancer.

"Gratifyingly, New Jersey holds first place in the Nation for achievement in this respect. The New Jersey Cancer Society is a grass-roots organization, with active chapters in every county. Laymen act with medical men on the local level, making certain that local hospitals pool whatever equipment can be made available and that local research goes into the vast world pool of research.

"It is not an unexciting business, this great crusade for well-being. Just as scores of thousands of scientists and laymen were assembled in the highly speculative search for the atom bomb, so laymen and doctors are being assembled in local, self-governing units throughout New Jersey and the Nation in an adventurous campaign to free the human race from a terrible scourge.

"Money is the least of the concerns of this organization. New Jersey oversubscribed its quota last year with ease. What is the subject of intense local pride is the fact that New Jersey ranks first in the Nation, not only in per capita contributions, but in the quality and relative number of its local, self-governing cancer societies.

"Every one of New Jersey's 21 counties has an active cancer society contributing to local welfare, as well as to the general cause. Medical projects of immediate aid to local residents have been launched, as a result, in 30 hospitals in 11 counties.

"This State has naturally attracted national attention, but it is to be expected that New Jersey will blaze the trail of progress sill further in the 1947 campaign."

*Comparative report, April 1947, medical-surgical plan of New Jersey—performance of operations*

| Items of operations | At end of April 1947 | At end of March 1947 | At end of April 1946 |
|---|---|---|---|
| BALANCE SHEET | | | |
| Assets: | | | |
| Cash (working funds) | $69, 781. 03 | $92, 684. 30 | $60, 141. 33 |
| Cash (savings banks) | 10, 225. 00 | 10, 225. 00 | 10, 125. 00 |
| Investments (U. S. Government bonds) | 177, 976. 63 | 142, 985. 33 | 70, 000. 00 |
| Accrued interest | 1, 132. 37 | 929. 76 | 509. 27 |
| Accounts receivable—Hospital Service Plan | 64, 469. 68 | 70, 438. 92 | 39, 060. 84 |
| Accounts receivable—subscriptions | 4, 252. 04 | 3, 889. 49 | 2, 941. 83 |
| Total | 327, 836. 75 | 321, 152. 80 | 182, 778. 27 |
| Liabilities: | | | |
| Unearned subscriptions | 35, 582. 10 | 32, 966. 02 | 19, 181. 29 |
| Claims outstanding: | | | |
| Reported | 67, 413. 00 | 57, 083. 50 | 29, 151. 35 |
| Unreported | 25, 000. 00 | 25, 000. 00 | 15, 000. 00 |
| Unpaid expenses: | | | |
| Medical Service Administration | ---------- | ---------- | 329. 30 |
| Other | 260. 30 | 8, 999. 06 | 4, 760. 18 |
| Reserve | 199, 581. 35 | 197, 104. 22 | 114, 356. 15 |
| Total | 327, 836. 75 | 321, 152. 80 | 182. 778. 27 |
| Reserve per enrolled person | 1. 90 | ---------- | 1. 96 |

| | Month of April 1947 | | Month of March 1947 | | Month of April 1946 | | Period Jan. 1, 1947, to Apr. 30, 1947 | | Period Jan. 1, 1946, to Apr. 30, 1946 | |
|---|---|---|---|---|---|---|---|---|---|---|
| FINANCIAL DATA | | | | | | | | | | |
| Earned subscriptions | $70, 700. 17 | (100. 0%) | $68, 259. 14 | (100. 0%) | $38, 329. 51 | (100. 0%) | $267, 788. 38 | (100. 0%) | $144, 263. 98 | (100.0%) |
| Claims (incurred) | 55, 946. 50 | (79. 1%) | 46, 604, 78 | (68. 3%) | 27, 855. 50 | (72. 7%) | 192, 255. 65 | (71. 8%) | 95, 469. 60 | (66. 2%) |
| Net operating expense | 12, 574. 37 | (17. 8%) | 12, 088. 51 | (17. 7%) | 6, 478. 49 | (16. 9%) | 47, 205. 48 | (17. 6%) | 24, 129. 83 | (16. 7%) |
| Total | 68, 520. 87 | (96. 9%) | 58, 693. 29 | (86. 0%) | 34, 333. 99 | (89. 6%) | 239, 461. 13 | (89. 4%) | 119, 599. 43 | (82. 9%) |
| Earned reserve | 2, 179. 30 | (3. 1%) | 9, 565. 85 | (14. 0%) | 3, 995. 52 | (10. 4%) | 28, 327. 25 | (10. 6%) | 24, 664. 55 | (17. 1%) |

| | | | | | |
|---|---|---|---|---|---|
| Add: Interest on investments | 297.83 | 231.94 | 106.78 | 857.62 | 393.98 |
| Less: Premium paid on bonds | ---------- | ---------- | --------- | ------------ | 943.75 |
| Total reserve | 2,477.13 | 9,797.79 | 4,102.30 | 29,184.87 | 24,114.78 |
| **ENROLLMENT DATA (PERSONS)** | | | | | |
| Total enrollment in force to date | 104,840 | 101,078 | 58,392 | ------------ | ------------ |
| Additions | 5,762 | 5,843 | 3,084 | 23,115 | 11,106 |
| Total deductions | 2,000 | 1,742 | 739 | 6,363 | 3,578 |
| Converted | 130 | 177 | 57 | 569 | 301 |
| Cancelled and pending | 1,870 | 1,565 | 682 | 5,794 | 3,277 |
| Net gain in persons | 3,762 | 4,101 | 2,345 | 16,752 | 7,528 |
| Groups enrolled: | | | | ------------ | ------------ |
| New groups | 36 | 31 | 13 | | |
| Total to date | 634 | 497 | 305 | | |
| Claim Data (On incurred basis) | | | | | |
| Average exposure (persons) | 104,298 | 100,825 | 58,125 | 98,776 | 54,286 |
| Cases | 915 | 678 | 453 | 2,955 | 1,512 |
| Amount | $55,946.50 | $46,604.78 | $27,855.50 | $192,255.65 | $95,469.60 |
| Annual rate of hospitalization | 1 out of 9.5 | 1 out of 12.4 | 1 out of 10.7 | 1 out of 11.1 | 1 out of 12.0 |
| Average cost | $61.14 | $68.74 | $61.49 | $65.06 | $63.14 |
| By participating physicians: | | | | | |
| Semiprivate cases | 589 76% | 395 76% | 282 77% | 1,811 78% | 927 76% |
| Private cases | 106 14% | 62 12% | 50 14% | 290 12% | 182 15% |
| Ward cases | 81 10% | 60 12% | 34 9% | 244 10% | 108 9% |
| Total participating physicians | 776 100% | 517 100% | 366 100% | 2,345 100% | 1,217 100% |
| Surgical cases | 552 60% | 438 65% | 290 64% | 1,782 60% | 906 60% |
| Medical cases | 199 22% | 145 21% | 104 23% | 650 22% | 358 24% |
| Maternity cases | 127 14% | 75 11% | 45 10% | 390 13% | 174 11% |
| Medical and surgical cases | 37 4% | 20 3% | 14 3% | 133 5% | 74 5% |
| Claim incidence per 1,000 enrolled | 105 | 81 | 94 | 90 | 84 |
| Adult male | 70 | 68 | 73 | 68 | 72 |
| Adult female total | 146 | 121 | 139 | 134 | 122 |
| Adult female—maternity | 40 | 24 | 24 | 33 | 25 |
| Adult female—other | 106 | 97 | 115 | 101 | 97 |
| Children | 96 | 45 | 58 | 61 | 46 |

Figures subsequent to Dec. 31, 1946, are subject to audit.

## IMPLEMENTING THE NATIONAL HEALTH PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION OF NEW JERSEY

Prepared by the Medical Society of New Jersey for the Council on Medical Service of the American Medical Association, 1947

### THE NATIONAL HEALTH PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION

1. Minimum standards of nutrition, housing, clothing, and recreation are fundamental to good health.
2. Preventive medical services should be available to all and should be rendered through professionally competent health departments. Medical care to those unable to provide for themselves should be administered by local and private agencies with the aid of public funds when needed, preferably by a physician of the patient's choice.
3. Adequate prenatal and maternity care should be made available to all mothers. Public funds when needed should be administered by local and private agencies.
4. Every child should have proper attention, including scientific nutrition, immunization, and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child-health centers administered locally with support by tax funds whenever the need can be shown.
5. Health and diagnostic centers and hospitals necessary to community needs are preferably supplied by local agencies. When such facilities are unavailable, aid may be provided by Federal funds under a plan similar to the provisions of the Hill-Burton bill.
6. Voluntary health insurance for hospitalization and medical care is approved, the principles of such insurance plans to be acceptable to the council on medical service and to authoritative bodies of State medical associations.
7. Medical care, including hospitalization, to all veterans should be provided preferably by a physician of the veteran's choice, with payment through a plan agreed on between the State medical association and the Veterans' Administration.
8. Research for the advancement of medical science, including a National Science Foundation, is endorsed.
9. Services rendered by volunteer philanthropic health agencies should be encouraged.
10. Widespread education in the field of health, and the widest possible dissemination of information regarding the prevention of disease and its treatment, are necessary functions of all departments of public health, medical associations, and school authorities.

### THE MEDICAL SOCIETY OF NEW JERSEY

### ORGANIZED MEDICINE AND HEALTH AND WELFARE AGENCIES

*Principles of cooperation:*

1. The medical society recognizes the need of supplying the professional and administrative leadership necessary to furnish public health services and adequate medical care to the people of the State.
2. The medical society will appoint the necessary committees to study the public-health and medical-care problems concerned, to supervise projects relevant to these problems.
3. The medical society pledges itself to maintain a high standard of professional skills among the medical personnel assigned to these projects, and to supervise such activities with a view toward maintaining high scientific standards and preventing personal exploitation.
4. The medical society invites and welcomes the active participation in its scientific programs by the qualified medical and nonmedical personnel of the appropriate health and welfare agencies.
5. The health and welfare agencies will render genuine cooperation with the medical society in the implementation of these projects.
6. The health and welfare agencies will select their part-time medical personnel from lists furnished by, or with the approval of, the medical society.
7. The health and welfare agencies will clear through the medical society any grievances concerning medical personnel.

8. The health and welfare agencies will protect the private practitioner and family doctor by discouraging treatment in preventive clinics, by returning to the family doctor any cases not suitable for examination or care at the health or welfare agency.

9. The health and welfare agencies will not profit financially by the labors of any medical personnel working there.

10. The medical society and the health and welfare agencies will seek the cooperation of dental, nursing, and pharmaceutical organizations in a program fashioned to accord with these principles.

11. The medical society and the health and welfare agencies will maintain continuing liaison with each other to implement these principles.

### THE PROGRAM OF THE MEDICAL SOCIETY OF NEW JERSEY

In 1931 The Medical Society of New Jersey adopted as a guiding principle for public health and medical care programs the recommendation of its child (public) health committee that "The Medical Society of New Jersey assume a considerable degree of leadership in public health and medical care fields by actively cooperating with all of the official and nonofficial State health and welfare agencies in the essential objectives of developing the best possible public health and medical services for all men, women and children in the State".

Later the child health committee was expanded to the public health committee which developed thirteen strong advisory committees; namely, committees on child health, maternal welfare, adult disease control, cancer control, cardiovascular disease, conservation of vision and hearing, crippled children, mental hygiene, nutrition, tropical diseases, school health, tuberculosis and venereal disease control. Each committee includes consultants from official State agencies involved in health and medical care programs and from nonofficial allied agencies. This organization is paralleled at a county level through each county society thus adapting the programs at a local level to meet local needs.

From 1939 to 1942 the program was further expanded by the organization of two nonprofit medical service corporations—Medical Service Administration of New Jersey and Medical-Surgical Plan of New Jersey. Medical Service Administration studies the need of the indigent and medically indigent and evolves plans to meet these needs with or without the aid of tax funds. Medical-Surgical Plan is a voluntary medical service plan designed to assist the self-supporting group during serious or catastrophic illnesses.

It is our desire to illustrate in this brochure how such a program may implement the Ten Point National Health Program of the American Medical Association in meeting the needs of the indigent and medically indigent by cooperation with official and nonofficial agencies. As illustration we present: (1) Monmouth County Medical Society Program of Integration with Monmouth County Organization for Social Service, and (2) the City of Newark Medical Care Plan, cooperating with official health agencies.

*Monmouth County* (*cooperation with nonofficial agency*)

Monmouth County is located on the Atlantic Seaboard. Its population is about 175,000 persons. It is about two-thirds rural and one-third towns and seashore resorts.

The Monmouth County Organization for Social Service is a nonprofit organization of Monmouth county citizens working through a professional staff for the betterment of health and welfare in the county. It is supported about 50 percent by philanthropy and 50 percent by local municipalities, and official agencies involved in the program. It is broadly representative of both public and private health and welfare agencies within the county thus serving as a coordinating agency to meet the county needs.

Since 1920 the members of Monmouth County Medical Society have served this county organization in an advisory capacity through their public-health committee and the appointment of their members who are qualified by training and experience to provide the medical services necessary in the program.

A review of the work done during a typical year is as follows:

I. *Prenatal Clinics.*—Held in two branch offices (health centers) of M. C. O. S. S. Fifty-one clinic sessions of 2 hours each held during the year with a total clinic attendance of 865. Each session served by a qualified physician who is paid $5 per clinic hour by M. C. O. S. S.

II. *Well baby conferences.*—Held at 16 locations throughout the county, either in branch facilities of M. C. O. S. S. or suitable facility made available by the municipality. Four hundred and seventy-nine clinic sessions of 2 hours each held during the year with a total attendance of 6,815 patients, served by one physician at each clinic session. The physicians are paid $5 per clinic hour either by M. C. O. S. S., the municipality, or a nonofficial agency in the municipality.

III. *Tuberculosis clinics.*—Held in 18 different localities in the county. Eighty-seven clinic sessions of 3 hours each, with clinic attendance of 1,823, each session attended by one physician from the staff of a State tuberculosis sanitarium.

IV. *Mental hygiene clinics.*—Held in five localities in the county. Eighty-nine clinic sessions of 4 hours each with 390 patient visits. Each clinic session served by two physicians from the staff of a State mental hospital.

V. *Venereal disease control clinic.*—Held in nine localities in the county. During the year 468 clinic sessions of 1½ hours each were held with a total attendance of 8,861. Each clinic session is served by one physician who is paid $5 per clinic hour through State and county funds.

The clinic facilities, nursing personnel and equipment for all of the above activities are provided through Monmouth County Organization for Social Service.

We urge that the American Medical Association in dealing with the rural health problem advise through the State societies that each county society assume a large part in the initiation of some type of county health effort coordination and that the medical profession assume a greater measure of responsibility in meeting all necessary community health needs.

*The City of Newark Medical Plan (cooperation with official agencies)*

This Plan was designed, at the request of the city of Newark, to meet the needs of the indigent population of the city. It has been in operation since 1943.

It is a "reimbursement" plan administered by Medical Service Administration with the advice of an advisory committee of Essex County Medical Society. Physicians bill Medical Service Administration for services rendered. Medical Service Administration pays for all approved services rendered and is reimbursed at monthly intervals by the city the amounts expended plus 10 percent for administrative costs.

It is administered in accordance with an informal "memorandum of understanding" signed jointly by representatives of Medical Service Administration, the Newark Department of Welfare and the Newark Board of Health. This memorandum sets forth the principles and objectives of the Plan, allowing for adjustment to meet unforseen contingencies.

In 1944 the Plan was expanded to include the "medically indigent" of the city, in addition to the indigent. The indigent are those whose names appear on the welfare rolls of the city. The medically indigent are those otherwise self-supporting persons who, in the opinion of the Social Service Bureau of the Board of Health, are unable to provide themselves with adequate medical care because of low income.

The Plan is limited to medical care rendered eligible persons confined to their homes with illness. It replaces a previous arrangement under which this care was rendered by salaried city physicians. It is limited to home care because we felt that the standards of medical care rendered in the public clinics and to in-hospital patients was adequate.

The initial fees were $2 per day call and $3 per night call. In April 1946 these fees were increased to $3 per day call and $5 per night call.

The Plan provides for free choice of physician and payment for physicians' services on a fee-for-service basis. Consultations, laboratory, and x-ray services are provided through the facilities of the Newark City Dispensary or by the admission of the patient to hospital. Prescriptions are filled at the Newark Dispensary up to 4:30 p. m. after which they may be filled by any lay pharmacist who forwards a duplicate prescription to the city for payment.

The cost to the city at fees of $2 and $3 was at the rate of 12.5 cents per month and at fees of $3 and $5 is 18.4 cents per month, per capita of indigent population.

Why is a "reimbursement" plan advisable in the care of the indigent and medically indigent? Because: 1, they require services in the home and office (or public clinic) of the physician, the rate of utilization of which cannot be predetermined, and 2, because the indigent and medically indigent load varies with economic conditions. In times of prosperity the load is small, composed mostly of those unemployable because of physical defects or illness, comprising a group with a high sick rate and high per capita costs. During times of depression the load is tremendously increased by healthy persons unable to find work, comprising a group with a relatively low sick rate and low per capita cost. Such unknown factors and variations do not permit of the application of insurance principles or of actuarial determination of costs.

That the Plan is a success is substantiated by recent communications received from The Honorable John A. Brady, director of public affairs for Newark, and Charles V. Craster, M. D., health officer of Newark. Mr. Brady says in part, "The free choice of physician is, in my opinion, essential for a proper relationship between the doctor and the patient—the Plan provides efficient and adequate medical care to the indigent poor of the city of Newark and the medically indigent—the actual cost of these calls to the city has been considerably less than when a full staff of district doctors was maintained."

We recommend that any unit of organized medicine contemplating a Plan for care of the indigent or medically indigent give serious thought to a Plan embodying the principles outlined above, to be administered by a professionally controlled agency which will impartially control medical care standards and abuses.

Senator SMITH. You made a statement, Doctor, with regard to infant mortality in New Jersey. We made a check-up on that matter, and I want to introduce in the record in connection with your testimony some data that appears in a pamphlet entitled "Factual Data on Medical Economics" Revised to 1940, which is published by the Bureau of Medical Economics of the American Medical Association in Chicago. I would like to introduce in the record at this point on page 76 chart XXXIV with the explanatory table on page 77, table 34, and on page 78, chart XXXV, and the explanatory table on page 79, table 35.

I would like also to quote from this same document this statement with regard to infant mortality in the United States just to indicate that progress has been made in dealing with that subject all over the country: "For the period 1915 to 1938, the recorded infant mortality rates for the United States declined 48.9 percent."

(The data and charts referred to by Senator Smith are as follows:)

TABLE 34.—*Infant mortality; original registration States; comparison of rates for the years 1915 and 1937*

| State | Deaths under 1 year of age per 1,000 live births | | Percent decline |
|---|---|---|---|
| | 1915 [1] | 1937 [2] | |
| Rhode Island | 120.3 | 47.6 | 60.4 |
| District of Columbia | 111.1 | 60.8 | 45.2 |
| Pennsylvania | 109.8 | 50.3 | 54.1 |
| New Hampshire | 109.6 | 48.1 | 56.1 |
| Connecticut | 107.1 | 40.4 | 62.2 |
| Maine | 105.4 | 65.3 | 38.0 |
| Massachusetts | 101.0 | 44.1 | 56.3 |
| Registration States | 100.0 | 46.9 | 53.1 |
| New York | 99.3 | 45.1 | 54.5 |
| Michigan | 86.0 | 47.9 | 44.3 |
| Vermont | 85.5 | 49.5 | 42.1 |
| Minnesota | 70.2 | 40.8 | 41.8 |

[1] Vital Statistics—Special Reports, Bureau of the Census, Mar. 1, 1938.
[2] Vital Statistics—Special Reports, Bureau of the Census, Jan. 13, 1939.

CHART XXXIV

## INFANT MORTALITY

### ORIGINAL REGISTRATION STATES

COMPARISON OF RATES FOR THE YEARS 1915 AND 1937

SOURCE: VITAL STATISTICS SPECIAL REPORTS, BUREAU OF THE CENSUS
(RATES AND PERCENTAGES ROUNDED TO NEAREST WHOLE NUMBER)

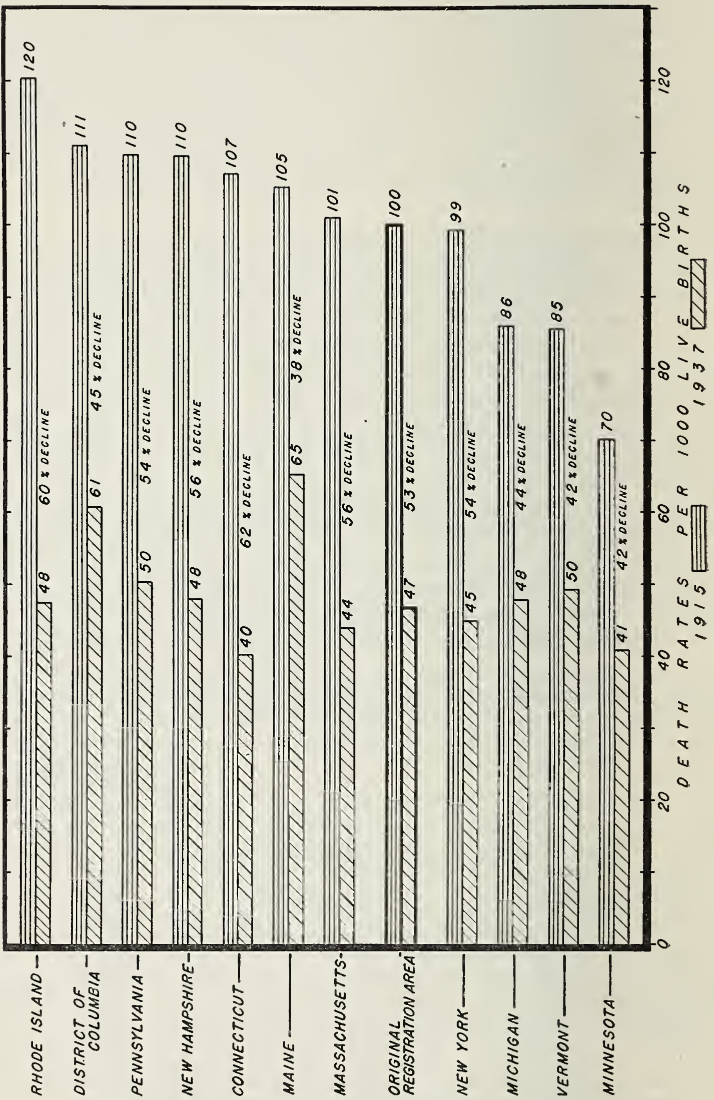
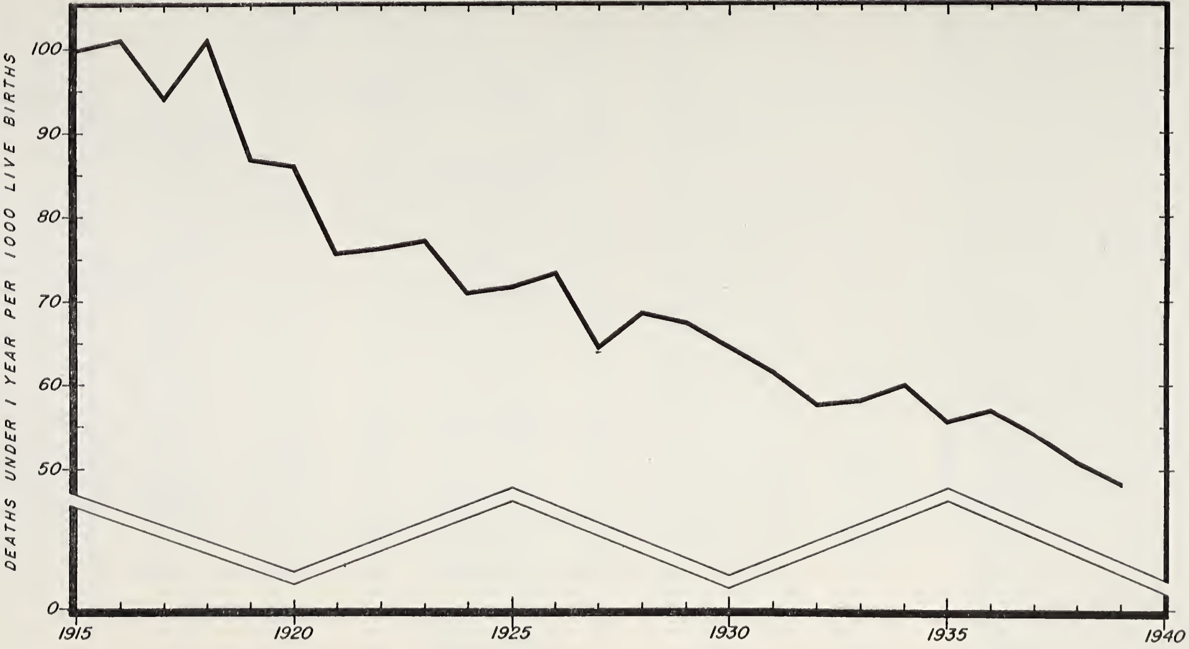


CHART XXXV

## INFANT MORTALITY IN THE UNITED STATES FROM 1915 TO 1939

FOR THE EXPANDING BIRTH REGISTRATION AREA

SOURCE: VITAL STATISTICS SPECIAL REPORTS, BUREAU OF THE CENSUS; AND THE METROPOLITAN LIFE INSURANCE COMPANY
1939 RATE IS PROVISIONAL



### Decline in Infant Mortality

The same statistical error of considering a gradually expanding "Registration Area" as a uniformly constant area has constituted the basis for the statements that there has been very little decline in infant mortality during recent years. The accompanying table and chart demonstrate this error by giving the figures for all the States concerning which facts are available for the 22 years preceding 1938. In these States the decline was 53.1 percent from 1915 to 1937.

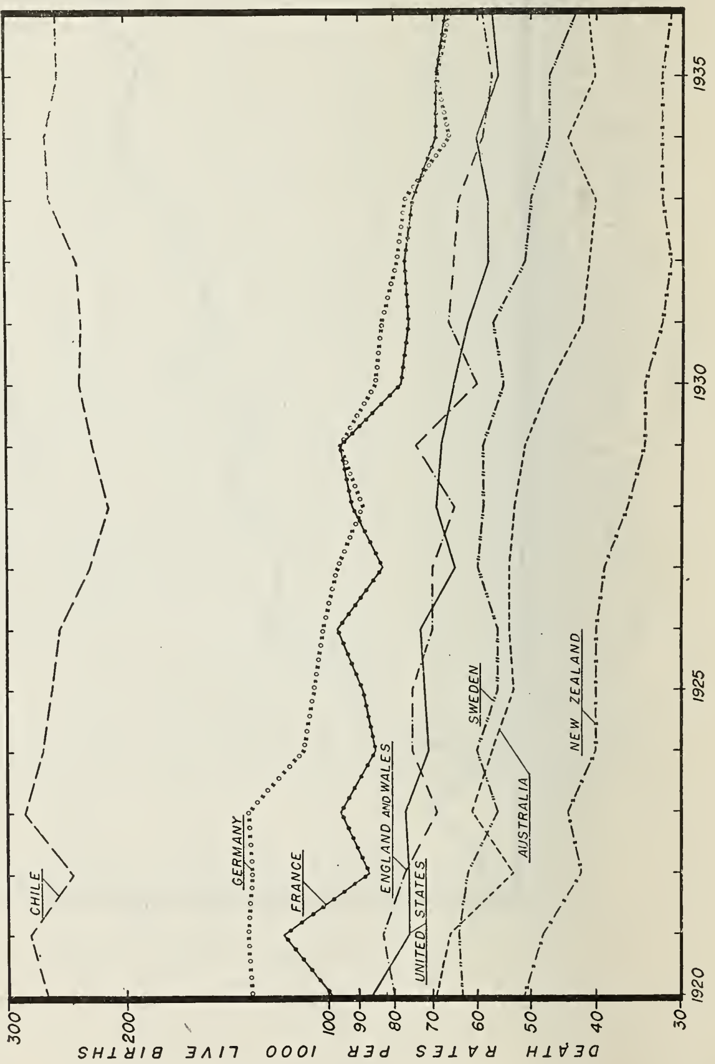
Some of those whose proposals, if adopted, would disrupt the private practice of medicine and place the medical profession under the control of lay administrators, promise to reduce the present infant death rate by one-half. The infant death rate was reduced by nearly one-half in the expanding birth registration area since 1915 and by more than one-half in the original registration area. The recorded performance of the medical profession, in coopeartion with public-health agencies, would seem to be better security for a future program than utopian promises. The medical profession in private practice through the

CHART XXXVI

INFANT MORTALITY RATES PER 1000 LIVE BIRTHS FOR SPECIFIED COUNTRIES, 1920—1936

(EXCLUSIVE OF STILLBIRTHS)

SOURCE: VITAL STATISTICS, SPECIAL REPORTS, BUREAU OF THE CENSUS



present system of health care is not asking for the retention of that system on the basis of promises but on the basis of past performances and present accomplishments.

Far from resting content with this accomplishment, nearly every State and county medical society in the United States is planning for even greater progress in protecting the lives of mothers and infants. Some of the practical phases of the program are: more and better courses in obstetrics and pediatrics in the medical schools and in the postgraduate instruction of practicing physicians; constant research in all phases of medical science applicable to maternal and infant care; more attention to the proper foods for mothers and infants; and constant cooperation with every individual, institution, or organization offering real assistance in furthering a program of protection of children.

This program was started by the medical profession many years ago and has received the sympathetic cooperation of public health agencies. It has been steadily improved as science added knowledge, and extended as resources became available. Its result, as shown in the figures of the above table and by the accompanying chart, indicate that there is no valid reason or excuse to abandon that program or to hand over its management to administrators who may be untrained in the science and art of medicine.

Senator Smith. Now I don't know exactly what the New Jersey figures are, but I assume that your papers show your figures. Compared with other States, would you say the New Jersey infant mortality rate is among the best?

Dr. Alexander. Those shown are taken from an authentic source.

Senator Smith. I am assuming now that you have documented these important statements you have made in your statement here with these exhibits that you have handed in, because when you speak of the infant mortality rate and these other matters having to do with the general health situation, I would like to have your documentation of it.

Dr. Alexander. We will forward those documents to substantiate everything we have said in the statement.

Dr. Quigley. The authority for those statements with respect to infant mortality, contagious and infectious diseases is contained in an article in the American Sociological Review dated February 1946 by Gearhardt Hershfeld and Carl W. Strobe. The comparative health factors among the States and those tables are in this article and have been quoted from this Sociological Review.

Senator Smith. Does the extract from the document appear in the exhibits you have here?

Dr. Quigley. No.

Senator Smith. I don't want to put the whole book in the record, naturally, but if you have taken out from that the figures to sustain the doctor's position, I would like to have that in with the source.

Dr. Quigley. We will send that in.

Senator Smith. I would like to get that table showing the comparative infant mortality in the different States, for example.

Dr. Quigley. I will present the whole thing after the finish, if it is agreeable.

Senator Smith. Now, Doctor, on the top of page 2, you refer, I think quite properly, to the responsibility of the individual, in the first place, for himself, then for his family and the community responsibility, and then, in the last analysis, the responsibility of the State. I imply from that that you feel, so far as New Jersey is concerned, it doesn't need any Federal aid at all.

Dr. Alexander. That is our feeling at this time.

Senator SMITH. You think you have taken care of the problems in the State of New Jersey with regard to the general health of the population?

Dr. ALEXANDER. We think we can.

Senator SMITH. Let me ask you about some specific things that we have been studying here and which we are all interested in. That is, part of this S. 545 contemplates a dental inspection service of all the children in the schools. I don't imagine New Jersey has had that yet, has it?

Dr. ALEXANDER. Very little of it.

Senator SMITH. Don't you think a dental inspection of the children in the schools in order to prewarn us against the possibilities of difficulty is desirable?

Dr. ALEXANDER. Yes; in principle, we are in accord.

Senator SMITH. It seems to me that we all agree to the importance of it. There is another bill being introduced entirely apart from this bill, though this bill contemplates the same thing, and that is a physical examination of all children in the public schools.

Dr. ALEXANDER. Is that part of the bill?

Senator SMITH. That is part of our bill.

Dr. ALEXANDER. We approve of that.

Senator SMITH. But are you prepared to take care of the costs of that in New Jersey without any Federal aid?

Dr. ALEXANDER. Yes; we are doing it now.

Senator SMITH. Have we provisions in the laws of New Jersey for inspection of all children in the schools?

Dr. ALEXANDER. No; the school boards do that now.

Senator SMITH. Do you cover that completely?

Dr. ALEXANDER. Yes.

Senator SMITH. How extensive an examination is that?

Dr. ALEXANDER. I suppose it would be quite extensive.

Senator SMITH. Is it a physical check-up each year? Do they go through it each year or do you just take the new children, check them and let them go?

Dr. ALEXANDER. I think in some places it is done every year.

Dr. QUIGLEY. You are speaking of the physical examination of the school children?

Senator SMITH. Yes.

Dr. QUIGLEY. It is being done. If you perhaps recall the conference we had with you and Senators Taft and Ball last December, we suggested the words "periodic physical examination of school children," and that was incorporated in the bill. It is the feeling of our public-health committee that the desirable way is to examine all children, all school children, periodically, and at more frequent intervals examine the children who show physical ailments. In other words, it is the feeling of our committee that a physical examination of all children every year is not needed.

Senator SMITH. In S. 545, we contemplate in the State-wide programs that the States, in order to qualify for Federal aid, would provide in 5 years hospital, surgical, and medical services to all those families and individuals in the States having insufficient income to pay the whole cost of such, and there would be a perodic physical examination of all children in elementary and secondary schools in the State. That is what I am referring to. Now in New Jersey, you are doing that in all the schools, and when you say periodic, that doesn't mean every year, or does it mean that one examination is made?

Dr. Quigley. It means that the idea, as our public-health committee envisions it, is to have all children undergo a complete physical examination upon entrance to school. That will screen out those who have no demonstrable physical defects and make it unnecessary for those children to be examined every year. It also will require those children with demonstrable defects to be followed through until those defects are taken care of. I might just ask Dr. Scott if that isn't his understanding.

Dr. Scott. Yes; that is my understanding, but as the plan operates at present, it is according to a local option. It is under the jurisdiction of our various boards of education in our municipalities as to how extensive and how frequent these examinations are performed. So that it varies in the different municipalities.

Senator Smith. I suppose if a child were noticeably ailing, that the teacher would call that to the attention of the school board.

Dr. Scott. I think there is no school board in New Jersey that doesn't have a physician assigned to it for the examination of school children or to be called into consultation by any teacher.

Dr. Alexander. I might say, in addition to the periodic examination in the schools, the school doctor regularly visits the school and the classrooms and checks those cases that the teacher or the principal in the school might want checked. That is what happens throughout the school year.

Senator Murray. It sounds to me like a very reasonable plan. I don't see how it could be improved upon.

Senator Smith. Well now, Dr. Alexander, on page 2 you use this language in the third paragraph, referring to a discussion of title VII of S. 545:

> It is our opinion that appropriations for the purpose of conducting the surveys contemplated by part A and for medical care services as provided in part B, should be limited to the 10 or 11 States of the South and Southwest whose economic conditions and relatively poor health records indicate the need of Federal assistance.

I am not quite clear as to how you selected those States and would limit your survey. S. 545 contemplated a preliminary appropriation, I think it was $3,000,000, to apportion that amount among the States, then have the States report back what their situation was, whether they needed help or not, et cetera. I don't see how we can pick out 10 or 11 States just arbitrarily without our having that preliminary survey. It seemed to us it would be fair to all the States to give them the opportunity to make that survey, and we can gather from that what the general set-up is and what their needs might be. It might turn out as you suggest, that there are only a relatively few States that do not have the set-up and need it.

Dr. Quigley. Senator Smith, our feeling with respect to the survey is not that the surveys shouldn't be made, but we feel that States like New Jersey or States with comparable resources should not be profferred or receive Federal aid for the purposes of the survey. We think New Jersey is well able to make the surveys contemplated by the Hill-Burton Act, for instance, which is under way now, and similarly the surveys that are contemplated here. I think our whole thought is that States like New Jersey should take care of these things themselves if they are financially able. It is not that we are objecting to the surveys. We think they are very desirable.

Senator Smith. But you feel that if, as a result of the survey, as you suggest, it would only show up 10 or 11 States, something like that, which would need Federal aid, that that Federal aid ought to be distributed on the basis of population. Is that your basis?

Dr. Quigley. No, sir. In our statement, we base our opinion upon economic conditions in those 10 or 11 States of the South which show apparently that they have the lowest income of all the States in the Union and also, relatively speaking, the poorest health conditions, and if the surveys show that very definitely, the point we wish to make is that those States which cannot meet the financial situation so far as the health needs are concerned, and the needs are definitely shown, then and only then should the Federal Government intervene.

Senator Smith. At this point, Doctor, in connection with your statement, I will read into the record from the same document I referred to before, Factual Data on Economics of the American Medical Association, table X on page 26, which is entitled "Distribution of Certain Medical Facilities and Percentage of Population Filing Income Tax Returns," and showing population and physicians in practice, number of hospitals, and so forth, in all the States in the order of their financial ability to take care of these things. I will quote also from this same document a comment on this table as follows:

> This table seems to reveal the existence of a health problem in the United States, but it is more of an economic than a medical problem and attempts to approach it exclusively from the medical point of view can only lead to confusion of issue and disappointment as to results.

Without commenting on whether I agree or not with that conclusion, that appears in this report in explaining this table.

Dr. Alexander. We make that point in our statement, Senator Smith.

Senator Smith. Yes. Well, I think this table will be helpful in connection with your suggestion of varying conditions in these States and which might justify us in helping some States and not helping others, unless we want to do an over-all program, which undoubtedly Senator Murray will talk about in a few minutes.

Now the next point comes up, Doctor, and I assume you will agree with this, that as we have in this country some States that are more wealthy than others, more income, and so forth, and New Jersey is one of them—we have got to recognize our State as one of the wealthiest States—it probably is reasonable that for such situations as we find in the South and Southwest to tax and take the funds from the wealthier States to help those depressed areas.

Dr. Alexander. That is our position.

Senator Smith. I think we all agree with that. We have come to a place in our economy where it is proper and correct that the wealthier States—I say that advisedly because I am from that State, but I think the greatest service the wealthier States could render would be to prepare some legislation to take care of these depressed conditions in certain parts of our country.

Dr. Alexander. We are in accord with that viewpoint.

Senator Murray. I think that is a natural and correct view. There are States even outside of the South that are in a very depressed condition. For instance, my State, Montana, is the third largest State in the Union, one of the richest States in the country in point of natural resources, a very wealthy State, and yet its population is declining and it is poverty-stricken because it has no balanced economy. It is a raw-material State where we produce ores and minerals and timber, cattle and farm products, all to be shipped out of the State, and as we deplete those resources, the State becomes poorer. Now, as a result of those conditions, during the depression, we had to bring hundreds of millions of dollars back into the State of Montana in order to relieve the conditions. Some people criticized that, pointing out that we didn't pay income taxes to justify the bringing of so much money into our State, and yet it had to be done.

We were not only hit by the depression, but by the drought as well. So the State suffered very severely. So that States like that, I think, are in the same category as these States in the South that are affected by very poor conditions. So I entirely agree with your views on that situation.

Senator SMITH. I think you will agree, of course, Senator Murray, if that policy is to be carried out, where some of the States are taxed to benefit the others, it requires an ever increasing care by the Government that the thing is done in a just way and not simply as the expression is, "soak the rich." I don't think that is fair. I am definitely opposed to that principle, but I do think that the wealthy sections of the country can reasonably be called upon and expected to take responsibility for helping the more depressed areas both in this field and education. Isn't that right?

Senator MURRAY. I agree with you thoroughly. I think an effort should be made also to allow some of those poor States to have a better balanced economy so that they can take care of their people. In Montana, for instance, as boys and girls are educated there, they have to leave the State. The president of the State University pointed that out several years ago. They have to go to other parts of the country to seek a living. Now Montana should be given an opportunity to do some of the processing out there. We produce all of these raw materials but have no processing plants. We produced chrome during the war, which was vitally important to national defense, but we had to ship it all the way to Niagara Falls and Pittsburg for treatment. If we had power facilities, we could treat that ore right at home. If we had cheap power we could process different kinds of farm products. So there should be an effort to give each of those States an opportunity to develop a balanced economy. Such a course would benefit the East.

We do not seek to take away from the East any of its established industrial enterprises, but we could have a little development at the same time and make a better market for the East. If we could do that, we wouldn't be here, trying to claim funds for relief in those states.

Senator SMITH. Dr. Alexander, on bottom of page 3, you speak of a survey that you made in 1939 with regard to people who might be in need of medical service. You say: "The society's purpose was well publicized by the press and radio for several weeks, and all persons who had been unable to secure needed medical services were asked to communicate with the executive offices of the society."

That strikes me as a very interesting experiment, and I wonder if the conclusion to be drawn is that, with the exception of these few, everybody in the State of New Jersey had adequate medical service.

Dr. ALEXANDER. Practically all of them. What brought about this survey is the very thing we have been talking about and listening to for the last 10 years: This great difference of opinion as to the needs of the various States, and we had all this talk about 30 percent of the population not being able to avail themselves of adequate medical care.

We didn't think that statement was sound, at least as far as New Jersey was concerned. So the medical society of New Jersey set up this program to determine for New Jersey just what the picture was, and we publicized it greatly through the radio, the press, and other sources. We wanted to know just what the situation was in New Jersey, and what we quoted in this statement is a result of that survey, that as far as New Jersey is concerned, very few people in New Jersey could not receive adequate medical care if they wanted it.

Senator SMITH. Did you demonstrate that the care was available?

Dr. ALEXANDER. Yes; to the vast bulk of the people. There were many people, of course, who would not avail themselves of these services, but the services were there for those who wanted to avail themselves of them. Dr. Scott would you want to add anything to that?

Dr. SCOTT. No. I would like to take that up when I am asked to speak.

Dr. ALEXANDER. All right.

Senator SMITH. On page 4 of your statement, Dr. Alexander, you state:

> We speak with some pride of two programs in operation in our State designed to relieve the financial strain of medical care and hospital services to people of modest income: The Hospital Service plan of New Jersey and Medical-Surgical plan of New Jersey.

I might say, Doctor, yesterday we had representatives here from Massachusetts and we had explained to us in some detail the so-called Blue Cross plan, which is supposed to take care of the hospital end of the thing, and the so-called Blue Shield plan, which is the medical and surgical end of that kind of group insurance. Is New Jersey's plan similar to those? Is the Blue Cross organized in New Jersey and is it operating in other States?

Dr. ALEXANDER. I might say Dr. Scott has headed his organization since its inception, and I think Dr. Scott is very well versed to discuss that phase of the program for the State society.

Senator SMITH. Let me just add also that I notice here that in addition to those plans, you have what is called medical service administration, which is aimed to take care of the indigent and the medically indigent. Is that correct?

Dr. ALEXANDER. Yes.

Senator SMITH. That takes care of the very lowest income?

Dr. ALEXANDER. Yes.

Senator SMITH. Doctor, you might say a word to get it into the record at this point about what we have in New Jersey so far as these group-insurance plans are concerned. Am I correct in my assumption that they are voluntary group-insurance plans and that we have no compulsory plan of insurance in New Jersey?

Dr. Scott. They are voluntary. There are no compulsory plans in New Jersey. Now, attached to the statement that Dr. Alexander read as presented to the committee was a list of exhibits setting forth how the medical society of New Jersey and its members cooperate with voluntary and official agencies to improve the adequacy of medical care distribution through cooperation with the health department programs, what we call our municipal aid programs, cancer society programs, the categorical relief group of crippled children, dependent children, old-age assistance, and so forth.

Of course, the operation or the development of these voluntary medical service plans must be evolutionary. We have very little to start on. We have very little actuarial data, very little information upon which to base costs.

We organized two voluntary service corporations. The medical service administration was organized first. The medical service administration is designed to deal with the problems of the indigent and the low-wage group by the use of tax money or voluntary contributions to provide payment for medical care.

The Medical-Surgical Plan is another voluntary medical service corporation to provide for the needs of the higher income groups, the so-called middle income groups, self-supporting people. By the way, in this program, we think in terms of the various social-economic groups in our State, and we recognize four social-economic groups.

There is first that group with ample income to provide payment for any contingent medical need comprising perhaps fifteen percent of our population. With that group we are not concerned. We then have a great middle-class group of self-supporting employed persons. Below that level, we have first an ill-defined group of self-supporting, otherwise self-supporting persons who cannot provide themselves with adequate medical care because of low income.

Senator Smith. That is what we call the medically indigent.

Dr. Scott. Yes, and below that we have the indigent. Now our work in New Jersey has demonstrated to us that the need varies according to the social-economic group. This great class comprising perhaps the majority of our population of employees, self-supporting persons on modest incomes comprises our greatest group.

Now we are convinced that that group does not need a complete medical care program. We are convinced of that for this reason: In 1939, we attempted to launch a complete medical care program, that is, providing for medical care in the home, in the office and in the hospital. We introduced that into 800 industrial groups and received practically no response. These people, without exception, told us:

> We don't want protection against the cost of minor illnesses. We can handle Johnny's measles. We can handle the acute respiratory conditions, the conditions which are cared for in the physician's office and in the home. What we would like is protection against the cost of serious illness.

So we went back and abandoned that plan and worked on our problem of catastrophic illnesses, and we believe that the needs of that group can be supplied through the medical-surgical plan. Then when you reach the medically indigent and indigent group, you have another problem. That group must be provided with a complete medical-care program, including medical care in the home, in the office, and in the hospital. They cannot afford to make complete payment of that from their income. The solution of it is not adaptable to insurance principles, and we must find some means of providing it outside of the insurance field. It is not subject to solution by insurance principles for these reasons:

The utilization of home and office calls is not a predictable contingency. Therefore, it is not subject to actuarial determination of costs. The second reason is that among this group, during periods of prosperity, the group is composed largely of persons unemployable because of physical defects; they have a high per capita cost for medical care, a high utilization rating. During times of depression, that we recently passed through, that group is tremendously expanded by healthy persons who cannot find employment but who are otherwise healthy with a relatively low per capita cost.

Now with such variations and unknown factors, you cannot apply the insurance principle in the solution of their problem. We believe that the solution to that problem is on the basis of a reimbursement plan, and experimentally, we have conducted such a plan in the city of Newark. The city of Newark contains about 50 percent of the indigent of the State. It is our largest municipality. Under this plan, the indigent and the medically indigent—now we don't refer to them as the medically indigent; we refer to them as the low-income group. The indigent are those persons whose names appear on the welfare rolls of the city. They are a fixed group. This low-income group or medically indigent group, if you prefer the name, is an ill-defined group. We don't know how extensive it is. But any family who in the opinion of the social-service bureau of the board of health cannot pay for its medical care is included in this program. All of these people are allowed free choice of physician. The physician sends his bills to our office. There they are screened. If there are any defects or abuses noted, they are corrected. We bill the city each month and the city pays us plus 10 percent for administrative cost. That plan has proven successful, and I believe the principles of that plan are applicable in any community or any State in dealing with this problem. It is the only fair way to do it.

If we do it on the insurance principle, we have to put our figures so high that it is unfair to the municipality or we put it so low that we cannot provide adequate medical care, but honestly administered by an agency which will control abuses and will control the standards of medical care, I believe it is the solution to the problem of this low-income group.

Now, you asked the question as to whether or not medical care was available to all people in New Jersey.

I think we can honestly say that in New Jersey adequate medical care is available to all of our people and attainable by all of our people, if they know where to get it, in accordance with the needs of the various social-economic groups. Certainly for the indigent through our municipal aid administration, which provides State funds for the care of the indigent, every indigent person may have adequate medical care. The low-income group, the so-called medically indigent, there is perhaps some question about that, until our State or municipalities appropriate sufficient funds to cover them like in the city of Newark. They certainly are not deprived of adequate medical care in any large municipality where there are hospital clinics.

There may be a group of low-income persons in our rural areas for whom at present medical care is not always easily attainable, but that is a very minor group. I think it is fair to say with all reasonableness that for practicable purposes adequate medical care is available in New Jersey to any person who needs it.

Senator SMITH. How do you finance, Doctor, this so-called medical service administration? Am I correct in saying that the explanation of this Newark Medical Plan appears among the exhibits here that you have filed?

Dr. SCOTT. Yes.

Senator SMITH. I find on the last page of the document which is entitled "Implementing the National Health Program of the Medical Association in New Jersey" what is called the city of Newark Medical Plan, and that explains the way this medical service administration appears to function. How do you finance the medical service administration?

Dr. SCOTT. The work of the medical service administration, of course, is experimental and evolutionary. It is financed by the medical society of New Jersey.

Senator SMITH. You mean by voluntary contributions?

Dr. SCOTT. No; by the budget from the medical society of New Jersey. They assign us a budget each year to make up our deficit.

Senator SMITH. How does the society of New Jersey get its funds?

Dr. SCOTT. From the physicians of New Jersey from the dues.

Senator SMITH. Then, this service is paid for by the physicians themselves?

Dr. SCOTT. That is right. That is the deficit. For instance, on this plan we charge 10 percent, with the load as small as it is today. Ten percent does not pay for the administrative costs of this plan. I think if we ever went into a depression where we had a quarter of a million or half a million people on our rolls, indigent and medically indigent, the 10 percent wouldn't cover the cost of overhead. It is a voluntary contribution by the medical society.

Senator SMITH. Well, that brings up the main issue, really, that we are discussing in these hearings. S. 545 provides for voluntary insurance plans in each State working out on the voluntary basis its program with Federal grants-in-aid. This aid will come from the general finance and general taxation system. Senator Murray's bill, which is the successor to the Murray-Wagner-Dingell bill of last year, calls for a compulsory health-insurance plan, a compulsory program, which means the deduction from the pay roll of workers of a certain percentage and a certain percentage amassed by the employer to raise an enormous fund all over the country to take care of the medical costs, and those of us who introduced the so-called Taft bill, S. 545, aren't prepared to go along at this stage of the game with any compulsory program of that sort. We feel we haven't got far enough to know how to deal with a program of that kind.

We think if the people were taxed today on their pay rolls for such service, that we are not organized here today to give the service that is expected. Senator Murray will probably ask some questions along that line, but he thinks the other approach is sound, that we ought to tax everybody and have an over-all Federal plan as the Murray bill calls for.

Dr. SCOTT. I think, speaking of New Jersey, that the needs of the self-supporting group can be met satisfactorily through these voluntary plans paid for by the worker or with perhaps a contribution by the employer.

Senator SMITH. Not compulsory, though.

Dr. SCOTT. Not compulsory, no, on an insurance principle. For the medically indigent and the indigent, of course, funds will have to be provided through taxation; there is no question. I think that group will have to have subsidized medical care; there is no other source of money to pay for the medical care if they are to pay for it.

Senator MURRAY. I think, Doctor, that we would all like to see a voluntary system develop that would be effective, but our studies of the situation seem to have convinced us that they haven't worked out in the past and that we will never be able to develop a voluntary system in the country that will be effective. Of course, it is in an experimental stage in some communities, and in your State you may find that you are making some progress with the voluntary system. We have discovered in many States where they have attempted voluntary systems that they have found it difficult, if not impossible, to make it completely effective so as to give complete medical care to the people. On my part, I would much prefer, if it were possible, to work out a voluntary system, but I am not convinced that that is going to be possible.

Dr. SCOTT. As I said, Senator, I don't think that a complete medical care program is needed by all of our people. There is no demand for a complete medical care program from self-supporting people.

Senator MURRAY. That isn't true. There is a natural tendency on the part of people to avoid seeking something for nothing, and especially as you mentioned a moment ago about some of the scattered sections of the State. There may be situations where the people are not getting the complete care. They hesitate to put themselves on record as asking for care of that kind free. They avoid coming out and admitting that they are incapable of paying for it and they neglect themselves. You will find all over the country that people have often neglected getting adequate medical care at the proper time.

Dr. SCOTT. Nevertheless, it is available to them. In New Jersey, I think it is available to them.

Senator MURRAY. Yes, it may be available to them if they want to go on record as being unable to pay and requesting charity they probably could get it to some degree, but they never have been able to get it in the past in such manner as to be effective. They have not been able to get complete medical care. Now I think the surveys and polls that have been taken in the country acknowledge that that is the real situation in our country. They are not getting adequate medical care for the great masses of our people at the present time because of its high costs and the natural tendency of people to avoid trying to get it. A man with a very fair income feels that he must conserve his money for the purpose of educating his children, clothing them, and feeding them. He naturally neglects himself, thereby putting himself in danger. Some time later on in life it is discovered that as a result of his neglect, he has gotten himself into a very serious state of ill health.

Dr. Scott. Medical care, of course, is expensive. It is just as expensive under a compulsory program as it is under a voluntary program. It is just as expensive under a compulsory program as if paid for by the individual over a period of years.

Dr. Alexander. Might I say something, Senator? I have practiced in a rural area for 36 years, 13 miles removed from the nearest hospital, and I can't recall any one of my patients in that area for a period of 36 years who hesitated to call the doctor when he needed him, whether he paid for it or not, and the financial aspect of it did not enter into it. If he couldn't pay, we just didn't charge him. As I say, I have lived for 36 years in my area and it is rare that I found anyone who did not get adequate medical care if he desired and wanted it. The trouble with a lot of people or a number of people is that they do not want medical care, not that it is not available. We have those followers of cults who do not believe in things we believe in. You take a certain percentage of people not receiving adequate medical care. It is not because it is not available, but because many of them do not desire it. However, as far as people who want medical care, regardless of the financial status of the individual, my experience over a period of 36 years in the district of my State has convinced me that they do receive it if they want it.

Senator Murray. Well, Doctor, while you will find there are some people who don't desire it, nevertheless, they need it and they are not getting it, and they are not getting it because they are unable to pay for it and they hesitate to seek relief and put themselves on record as not being able to pay for it.

If we had some kind of system whereby anybody could get the best kind of modern medical care without having to go on record as seeking relief or assistance, I think the people in the country would avail themselves of it, but they hesitate under present existing conditions because they don't want to put their family in a position of seeking charity and having a reputation of not being able to pay their way.

Dr. Alexander. Senator, that may be true in some instances in the large cities, but again I come back to my own experience, where the vast majority of our doctors in the rural areas say that people send for the doctor when they want him and the question of money does not enter into it. Now these same people who do not want medical care or avail themselves of medical care under our present system would not avail themselves of medical care under any compulsory system because they do not believe in it. You take the Christian Science people. If you have a free system or a compulsory system, those people would not avail themselves of medical care. So you see, when you make your analyses of the problem, you must bear in mind the factors not relating entirely to the practice or the availability of medical care.

Senator Murray. Of course, in the big industrial States in the East, society is highly developed, whereas in other sections of the country, where we have the so-called backward States, they haven't the facilities. I know in my State, in Montana, they have no hospitals or clinics within reasonable reach of some communities at all. They have to go long distances and they can't get medical men to settle in those sections. I know counties there where they were left completely without medical care back during the depression. Doctors were compelled to leave. They have their own families to take care of. They can't afford to practice medicine without getting an income. They have to educate their own children and take care of themselves. In one county in Montana in 1936 there was only one doctor left in a rural section and he told me he was leaving. He said he was very sorry he had to leave. I had to wire to the Red Cross to get emergency help because there was considerable illness there at that time.

So we have these varying conditions in the country, and it may be that in the industrial sections of the country, in rich States, they may be able to do better. Now under our plan, the compulsory system, we provide that each State have complete control of the administration of the act. The medical profession will have representatives on the boards and the boards will have complete control of the program.

It seems to me that throughout the country there is a great demand for some kind of adequate medical care system which would make it possible for people to get modern medical care.

Dr. Scott. Well, Senator, in New Jersey we have what you might call a slogan and that these problems should be cared for at a local level to meet local needs. Certainly if there is a county in need of additional medical care, that is a local problem; I don't think it could be solved by an over-all national program. We cannot get doctors to settle in some of the counties of Montana under any type of program because doctors settle in areas where there is a proper social environment for their families. That is what keeps these doctors out of many of these rural towns. I don't believe a compulsory program is going to ever alter that situation.

Dr. Quigley. Could I add something there, Senator? In some of these areas it may resolve itself into a proposition of where they will have to have some governmental physicians assigned on a decent salary. I think that is Dr. Scott's opinion, too.

Dr. Scott. Yes. Whatever the local problem is, it calls for a local solution. I don't think any of those situations exist in New Jersey, where we have an average in all of our counties of a physician to 750 population.

Senator Murray. Well, these conditions are spread all over the country, it seems to me, and even in some of the highly industrialized States the problem exists just as well as it does in the poorer States, and it is a matter that requires great study, I admit. We had very extensive hearings on the national compulsory bill that we considered here last year and the year before, and as a result of those hearing, we have tried to improve the bill insofar as its administration was concerned and to permit the States to have local control of its administration. Have you seen this new bill which we have introduced in this session, Doctor?

Dr. Scott. I haven't had a copy of it. I have read reviews of it.

Senator Murray. I can furnish you with sets of the copies of it together with an abstract of its provisions with some of the statements that were made in connection with it so that you may have it for your study. I certainly appreciate your testimony here this morning. I think it will be very helpful to us.

Senator Smith. I just call attention to one of the matters in S. 1320, one of the provisions; I suggest you read the whole part with regard to the administrative provision on page 39, subparagraph (b). It says:

> All functions of the board—

that is, this control board—

> shall be administered by the board under the direction and supervision of the Federal Security Administrator.

It contemplates bringing the whole health program under the Federal Security Administrator. · That raises a question which I would like to ask you gentlemen. I understood you to speak of the social service bureau of your board of health, and I gathered from that that you believe that the proposal in our S. 545 to have administrative supervision under the health department is a wise set-up. You don't want to be under a social service bureau to determine, for example, the status of patients, whether they can afford to pay or not, or do you think that should be determined by the social service bureau?

Dr. SCOTT. I think that should be determined locally. The social service bureau in Newark is an integral part of the board of health. Somebody has to determine the eligibility of a person for medical care. I don't know if it makes much difference what title you put on the group that determines that.

I would like to make a statement in reference to Mr. Murray's statement that people objected to the embarrassment connected with asking for medical care. We obviate that in Newark. All of these persons are given identification cards. It is nobody's business except their business and the physician's that they are receiving free medical care.

Senator SMITH. No publicity to it.

Dr. SCOTT. There is no publicity to it. They are issued an identification card stating that they are entitled to medical care under the city of Newark plans. So it is purely confidential between them and the physician. Their neighbors don't know who is paying for the doctor when the doctor's car drives up to their home.

Senator SMITH. I am glad you added that because that point has been raised a good deal.

Dr. SCOTT. There is no need of embarrassment to any family in receiving free medical care if it is administered properly, and I think that is one thing that have to pay attention to in the administration of these plans. I feel that the city of Newark plan has had a tremendous moral effect upon the indigent and medically indigent persons in New Jersey, the mere fact they are able to call their own physician, many of whom had physicians years ago before they met with hard times or were crippled, and it is a great relief to them to be able to call and feel free to call their old physician who is always glad to take care of them.

Senator SMITH. Well, we certainly are very grateful to you doctors for being with us this morning. Have you anything further to add?

Dr. ALEXANDER. I would like to comment on the statement that Senator Murray made regarding compulsion. Senator Murray talks about the problem in Montana. He is more familiar with that problem in Montana than we are. We are in New Jersey and we are more familiar with the problem in New Jersey than he is. We cannot conceive or understand how a health program on a national-compulsion basis would improve medical care just because there is a problem in Montana and a few other States in the Union. We just can't understand that philosophy of thinking.

Senator SMITH. That is in line with your statement, I take it, that there may be some States that need special attention and they should receive Federal grants-in-aid to work out their salvation, but that that doesn't necessarily apply to the entire United States.

Dr. ALEXANDER. Yes; and compulsion on a Nation-wide basis certainly is not the solution, just because there might be a problem in 10, 11, or 12 States.

Senator MURRAY. Doctor, I think it goes further than that, I think that the people of this country through various organizations have gone on record time and again to the effect that they are not getting adequate medical care. Take, for instance, these big labor organizations like the AFL and CIO and the Grange and the Farmers Union and other organizations throughout the West. They have pointed out time and again that they want more adequate medical care, but aren't getting it. Farmers have come here from all over the country, representatives of farm organizations and other organizations pointing out that the country is not getting it, and while you say that perhaps are some people who don't want it, nevertheless, they need it and they ought to have it; and if you say there is no need for any embarrassment because it is a matter entirely between the patient and the doctor and no publicity is given to it, nevertheless, there is a consciousness there that a person seeking that kind of assistance may be looked upon as an inferior citizen, that he is not paying his way. It would be much better I think if we could develop some kind of system where every person could stand on the same level and get the medical care needed without feeling any inferiority.

Dr. ALEXANDER. Senator Murray, you are talking of a very small portion of our population. I am discussing the bulk of our people for whom we have a program for adequate medical care. We can see that a great many of our people today are not and have not received adequate medical care, but with a program such as we have in New Jersey and such as they have in most of the States of the Union, provision has been made for the bulk of our people so that they can receive adequate medical care at a cost that they can pay.

Senator MURRAY. Well, the bulk of the people in this country are made up principally of the working class.

Dr. ALEXANDER. That is right.

Senator MURRAY. And the working classes are the ones that are complaining about the situation through their organizations. They have gone on record time and time and have made this an important issue in their organizations, and that doesn't prevail merely in the backward States. It prevails in all the big industrial States in the country—in Michigan, New Jersey, New York—every place throughout the country. These organizations have gone on record time and again and polls have been taken, Gallup pools have been taken, where they discover that the people feel that they are not getting the medical care they need and that something should be done about it.

Dr. SCOTT. I am sure, Senator, that if these labor organizations would get behind a voluntary movement and give us their assistance, we could solve the problem on a voluntary basis. I think the majority of them have the opinion that under a compulsory health-insurance program, they are getting something for nothing. We can demonstrate to them that they are not getting something for nothing and that their neds can be met on a voluntary basis at less cost to them than through a compulsory program.

Senator MURRAY. I don't think they are seeking to get something for nothing. I think what they are trying to do through the insurance system is to reduce the individual cost by having a complete system so that, by all paying into that, the individual cost would be greatly lowered.

Dr. SCOTT. Of course, that can be done on an insurance basis also to meet their needs. I do not say it could be done on an insurance principle to cover the care of minor illnesses, but they do not want insurance to cover the cost of minor illnesses when you get right down and explain the facts to them.

Senator SMITH. We have some other witnesses this morning, so thank you, Doctors, very much for coming here.

The next witness is Dr. Lowell S. Goin, of California. I notice, Doctor, in the opening of your statement here you give your biography, so I imagine you wouldn't have to add to it.

(Subsequently Drs. Alexander, Quigley, and Scott submitted the following letter and article:)

CITY OF NEWARK,
DEPARTMENT OF HEALTH,
*Newark, N. J., April 7, 1947.*

To: Dr. Norman M. Scott, medical director, Medical Service Administration of New Jersey, Newark, N. J.
From: Dr. Charles V. Craster, health officer.
Subject: Medical Care of the Indigent.

DEAR DR. SCOTT: I have yours of the 1st and am enclosing copy of an article which I prepared on the subject of medical care for the indigent and medically indigent.

As to my opinion of the efficiency and adequacy of our present plan of handling home calls for the medically indigent and relief clients, I do not hesitate to state that it is working exceptionally well with satisfaction to the patients, the doctors, and to the department. The supervision which you for the medical administration, and Dr. Haskin for the health department, provide has made this plan successful. Without such supervision even this plan might have become as unsatisfactory as was the ERA arrangement.

Yours very truly,

CHARLES V. CRASTER, M. D.,
*Health Officer, Department of Public Health.*

### STATEMENT BY PUBLIC AFFAIRS DIRECTOR JOHN A. BRADY, NEWARK, N. J.

The plan which I formulated in November 1943, providing for medical attention for relief clients unable to leave their homes, has proved sound in all its phases to date. Prior to the inauguration of this plan I held a conference with representatives of the Medical Service Administration of New Jersey, sponsored by the medical societies of New Jersey, the health officer of this city, the director of relief—both of the last-named are under my jurisdiction—and a representative of the State department of economic development. At this meeting the program for a new payment plan for the care of the indigent sick and the medical care of persons active on the relief rolls of the Newark Department of Public Welfare was worked out.

The indigent patient under the aforesaid plan is now permitted to receive the services of his personal physician for the first professional call during his illness. In the event the patient is unable to contact his doctor, he may call the Newark Bureau of Health, who will request the doctor residing nearest the patient's home to accept the case. Should it be necessary for the physician to make additional calls, approval must be received from the health department.

It is most important that the client understand that, should his condition permit, he must continue to receive his medical care at the Newark city dispensary in the bureau of health because the new plan makes no provision for the payment of fees for services rendered in the office of the physician. The cases which require consulting service will be admitted to the city hospital or referred to the city dispensary.

The public-welfare department has expended the sum of $9,294 to December 31, 1946, and 4,059 home visits were made by the physicians operating under this plan.

As indicated by Dr. Charles V. Craster, health officer of the city of Newark, prior to the inauguration of the present program, the sick indigent person had no choice of a physician, the calls being made by the particular physician allocated to the city district. Considerable dissatisfaction occurred at times with the attitude of the visiting physician who by reason of the number of calls allotted could devote little time for examination and treatment of patients. The number of visits, under the old plan, given to each district physician gave a return on frequent occasions to the physician of 30 cents or less for each visit, which accounted for the quality of this service being below the standard maintained for paid services to the private patient.

The free choice of physician is, in my opinion, essential for a proper relationship between the doctor and the patient.

The new plan provides efficient and adequate medical care to the indigent poor of the city of Newark and to the medically indigent—that is, those families in the low-income group who, after investigation, were found unable to pay for medical service. Services are limited to those persons whose names appear on the current list of indigents on the active relief rolls of the city at the time medical service is rendered.

The actual cost of the calls to the city has been considerably less than when a full staff of district doctors was maintained. There has been no complaint as to the type or quality of medical service rendered, which was not the case with the previous salaried force. The actual decrease in the number of calls for medical service in the home has been considerable since the system of social-service investigation was made a routine service for each request.

Medically indigent persons in the city of Newark (not on the relief rolls of the department of welfare) must obtain permission for the first call from the department of health. Verification of each case as a medically indigent case is made by the city dispensary social-service bureau. When it is found that a patient is able to pay for the call or subsequent calls, the patient's name and address is forwarded to the claims division of the department of public affairs for payment.

John A. Brady,
*Director, Department of Public Affairs.*

## STATEMENT OF DR. LOWELL S. GOIN, PRESIDENT, CALIFORNIA PHYSICIANS' SERVICE, LOS ANGELES, CALIF., ACCOMPANIED BY WILLIAM M. BOWMAN, DIRECTOR, CALIFORNIA PHYSICIANS' SERVICE, LOS ANGELES, CALIF.

Dr. Goin. I would like to say, Senator, that I am appearing on behalf of the California Medical Association, of which I am past president, the American College of Radiology, of which I am past president, and the California Physicians' Service, of which I am the president. With me is Mr. William Bowman, who is director of the California Physicians' Service of Los Angeles, Calif.

Senator Smith. All right, Doctor, if you will go ahead.

Dr. Goin. I find myself in general agreement with the purposes set forth in this bill.

Senator Smith. You mean by that S. 545.

Dr. Goin. Yes. I regret to say that I cannot agree in every respect with every particular. I think that there is no doubt that a problem of the distribution of medical care actually exists. It does not exist for the reason commonly alleged by the social reformer but rather because we live in a complex social economic milieu, and because medicine has become so vast in the scope of its knowledge, that it becomes increasingly difficult to apply this knowledge well for the benefit of sick humanity under our present method of distributing medical care. The present bill, in my opinion, represents the first intelligent attempt that has been made to cope with this problem on a national level.

I might point out to you that all discussions of the whole problem of medical care are confused by a recently developing tendency to use the words "health" and "medical care" as though they were interchangeable words, as though one were a synonym of the other. Nothing is further from the truth. Medical care is, in fact, only a part of the problem of health and not even the most important part, since health depends almost entirely upon good nutrition, good housing, adequate clothing, adequate rest periods, adequate recreation, sanitation, hygiene, the regulation of patent-medicine advertising, the control of the cults, and so forth. Medical care consists of the care of the sick and injured, while health consists in not being sick or injured and dependent almost entirely upon the factors I just enumerated.

It seems to me that the Federal Government, if sincerely interested in health and welfare of the people, might well turn its attention to some of these other problems rather than attacking the minor fraction of the problem called medical care and to promise a miracle by solving that problem.

I think that it is debatable that the care of the health of the American people is a natural function of the Government. All history seems to indicate that the best government is that which governs the least, and the constant intervention in the private lives of citizens by the Federal Government is a thing which I view with alarm. I am not even sure that we should take money from the taxpayer, transport it to Washington, and return it to the several States from which it came, since this, too, represents one more bit of paternal intervention by the centralized Government.

Perhaps I am wrong in this opinion, but I am a sturdy believer in the rights of the sovereign States and I dislike to see intervention by the Federal Government which is not of absolute necessity.

I am certain that the policy expressed in section 2 of the pending bill, namely, that it is the policy to make available medical, hospital, dental, and public-health services to every individual, regardless of race or economic status, is not a sound policy, since people who are economically able to care for themselves should by all means do it, since it is thus that our individuality is preserved. Nevertheless, the general intentions of this bill are most commendable, and I am pleased to be able to endorse them.

There is no doubt that at present health and medical functions are widely scattered through the various departments and agencies of the Federal Government and that it is an excellent thing to collect these agencies into a single national agency as the bill proposes to do.

Senator SMITH. In reference to your earlier statement, where you say:

> The policy expressed in section 2 of the pending bill, namely, that it is the policy to make available medical, hospital, dental, and public-health services to every individual, regardless of race or economic status, is not a sound policy—

evidently you disapprove of that statement of policy.

The wording of the bill is this; I just call it to your attention. Page 2, subparagraph (c), reads as follows:

> It is the policy of the United States to aid the States through consultative services and grants-in-aid to make available medical, hospital, dental, and public-health services to every individual.

It isn't to furnish the service. It is to see through the cooperation of the States that the service is made available. Maybe that sounds like a distinction without a difference, but I think there is quite a difference, because we don't propose in this bill to provide this medical aid through Federal intervention. We simply want to supplement what the States are doing.

Dr. Goin. My point is that I don't believe that people who are economically able to supply themselves with medical care should have any sort of assistance from the State or Federal Government in getting it.

Senator Smith. We agree with that, and we don't propose to give aid to anyone who is able to pay for it.

Dr. Goin. Referring to the coordination of these various activities into a single agency, I would like to point out that the Pure Food and Drug Act obviously has to do with the health of the people, and I feel that there is no doubt that it should be coordinated in an agency such as is proposed in the current bill. If the bill were to have no other effect than the coordination of these now widely scattered agencies, the bill would be a good bill for that reason alone.

I am in grave doubt as to section 203 of title 2, which authorizes the Surgeon General to expend $10,000,000 each year for developing more effective measures for the prevention and control of cancer and to assist the States and political subdivisions of the States to establish and maintain adequate measures for the prevention and control of cancer including the provision for appropriate facilities for diagnosis, etc.

I might comment there just as you did with Dr. Alexander and say that this cancer approach would probably be taken out of this bill and incorporated in the National Science Foundation. That provision was made for a division of medical research.

Senator Smith. I think the purpose of the section in our bill was more diagnosis than research.

Dr. Goin. That is right; that is the point I am making, and that is what I object to. I think that an appropriation of money for the general purpose of research into the nature and cause of this disease is a most commendable thing and, indeed, I suspect that a much larger sum should be made available.

Senator Smith. There will be.

Dr. Goin. But as for the diagnosis and diagnostic fields, I see no reason to provide $10,000,000 for the diagnosis and control of cancer than to provide a similar sum for the control and diagnosis of gastric ulcer, arthritis, or any other disease. As a matter of fact, more people actually die of heart disease than die of cancer, and perhaps it would be even more appropriate to appropriate an even larger sum of money for the control of heart disease.

Since there is only one other section of the bill of which I feel critical, perhaps I had best deal with it at once.

In section 712, there appear the words—

> No plan or modification shall be disapproved because the Director disapproves of the methods proposed if the program is designed and calculated by July 1, 1952,

> to provide hospital services, sugical services, medical services, and periodic physical examinations as required by section 712, paragraph A.

and to this is added

> It is intended that the States shall devise in each case the methods by which this end is attained.

These words appear to me to permit a State to institute a system of compulsory sickness insurance, the Federal Government giving a grant-in-aid to such State for the purpose of administering such a compulsory sickness insurance program. If that is the intent of the bill, and I am not too clear as to the language, if that is the intent of the bill, then I oppose that very strongly. I am, and always have been, in complete opposition to any system of compulsory sickness insurance, and if that is the intent of the bill, I object very strenuously to that particular section.

Senator SMITH. Well, I think the purpose of the bill is to allow each State to work out its own salvation as to what its medical program should be, and we do not prohibit their having a compulsory system of that sort or something if the State wants to try it. It might be interesting if some States should try it and see whether the system would work. I agree with you heartily that I am opposed to a compulsory system Nation-wide, and I have no confidence whatever that a compulsory system could be successful, knowing human nature as I do, but we didn't say that a State wouldn't be allowed, if it wants it, to put in a compulsory system.

Dr. GOIN. Well, the whole matter confused me considerably, because this is the language of paragraph 4 of subsection A of the same section:

> Such programs may at the option of the State provide medical-care services in one or more of the following ways: in institutions, in the home or in physicians' offices; such program may also provide for the furnishing of such services to such families and such individuals by means of payments in the nature of premiums or partial premiums, or reimbursement of expenses, or otherwise by the State to any voluntary health, medical, or hospital-insurance fund or other fund not operated for profit, etc.

It seems to me there is some conflict there. I am not at all clear as to what the real intent is. One seems to cancel the other somewhat, but, in any case, if the intent is to subsidize the State compulsory health insurance program, then I oppose that particular intent.

Senator SMITH. No, it doesn't intend to do that. It intends to determine what the grants-in-aid are, what the States are entitled to, if it has a program that falls within the general requirements of the bill, which are limited, that is, these low income groups and these physical examinations of the children in school. That is about all that we would require the States to show they are planning to do in order to get their share of the grant-in-aid provided for. Of course, it does contemplate that the State can pay premiums to such organizations as the Blue Cross, for example, for people who aren't able to pay their own premiums. That is a way by which the indigent or the medically indigent can be taken care of.

Dr. GOIN. Since I am greatly interested in voluntary health care plans, I consider the development of such plans to be entirely in accord with our American tradition in which people care for themselves, rather than become the dependent wards of the State. It is my sincere belief that voluntary health insurance, if left to develop untrammeled by any compulsory sickness insurance plan, and in particular if aided by the States so that the medically indigent may be included in such plan, will develop and administer much better medical care than the people will ever receive under any sort of compulsory insurance plan.

It is interesting to note that to the best of my knowledge and belief, no compulsory sickness insurance plan thus far presented has made the slightest effort to care for these medically indigent people, leaving them exactly where they are now, a burden upon the charity of the medical profession. Voluntary health insurance would afford an excellent means for the State to render medical care to persons totally or partly unable to pay for it, by the simple means of subsidization of these people by payment of their premiums, or part of their premiums, to existing voluntary health care plans. Incidentally, I note that the bill refers frequently to voluntary nonprofit plans. Although I have no interest in any except a nonprofit plan, I really see no reason why commercial insurance carriers who are prepared to offer adequate health care plans should not have their premiums paid likewise, since the objective of such legislation is not the establishment of any particular method of caring for the sick and injured, but simply of insuring that care is available to them. Certainly in our American system, the making of a profit is no sin, and I repeat that I see no reason why commercial insurance carriers could not easily be included in the proposed program.

As to voluntary prepaid plans, the social reformer argues that there are many objections to them, that there are not a sufficient number of people covered, that people will not provide themselves with voluntary coverage, that the existing plans do not offer complete coverage, that preventive medicine is not sufficiently emphasized, and that protection of the citizens' health is a natural function of the Government.

I have already spoken of the theory that the protection of the citizens' health is a natural function of Government, stating that I thought it a debatable doctrine. Let us now consider the additional objections.

It is true that not nearly as many persons are covered as would be covered by a national compulsory plan. But does this mean that people should be compelled by law to do something for their own protection, something that they thus far seem not to be persuaded is essential? As experience develops, as an increasingly large number of subscribers are protected, will not these (if they are satisfied with their coverage) urge their friends and relatives to buy voluntary insurance protection and, if the plan is bad, will it not fall of its own weight?

Why, then, must we suddenly impose a new, untried, and highly experimental plan upon the American people? If voluntary insurance proves inadequate or unsatisfactory, it may be terminated at any time by those who are insured since, if they become dissatisfied, they will simply cease paying for unsatisfactory service.

All experience, however, indicates that a compulsory plan, once enacted into law, is never repealed, but is simply compounded by amendments, Executive orders, and decrees. More than 30 million people are now covered by one type or another of voluntary health insurance, and it seems reasonable to assume their satisfaction with it, since they continue to pay their premiums.

To the argument that not enough people will protect themselves without compulsion, there are two answers. Seventy-one million of our people have protected themselves with life insurance which they bought and continue to pay for of their own free will, simply because they have been persuaded as to the necessity of so doing. Of course, this vast number of insured was not reached in the first few years of selling insurance, nor should we expect tremendous numbers to enroll themselves in health-insurance plans until educational campaigns have had an opportunity to persuade them, and if, after such opportunity has been afforded, people still decline to buy health insurance, will it not indicate their disinclination to budget themselves for medical care, either voluntary or compulsory? And are we not still free men capable of deciding for ourselves without the intervention of an all-wise Government?

Existing voluntary plans do not offer complete coverage (although some of them approach it rather closely), nor does the currently proposed compulsory plan, in spite of claims to the contrary. Complete coverage is not yet offered because we simply do not know how to do it, nor do those who demand enactment of compulsory insurance.

I might point out to you that the last Murray-Wagner-Dingell bill authorized the Surgeon General to be charged for the first two visits to the doctor in any illness if he thought it best.

Many voluntary plans offer protection which is complete except for the first two visits to the doctor, a reservation which is necessary to protect the plans from frank imposition, but which could scarcely be held to be a very serious obstacle to obtaining medical care. Little as the compulsory-insurance proponents say about it, an identical provision was contained in the last Murray-Wagner-Dingell bill. Complete coverage will be offered by voluntary plans as soon as the necessary experience has accumulated. Without experience, it cannot be offered, nor can the necessity for experience be bypassed by writing a law.

Preventive medicine is a phrase much beloved by the social reformer, who seems to have a childlike faith that a visit to the panel practitioner will prevent disease. The hard fact is that medicine has not yet attained to the goals wished for, and that most talk about preventative medicine is wishful thinking.

How shall we prevent heart disease (except that due to rheumatic fever)? What examination today makes one aware of the coronary disease impending? How do we prevent cancer of the stomach and intestinal tract? The plain, hard answer is that there is no such examination, and that we do not know how to prevent cancer, and yet these are the two greatest killers that we know. Moreover, it will be well to know compulsory health insurance proposes to accomplish miracles in preventive medicine.

Senator PEPPER. We are all interested, Doctor, in cancer and heart disease, and I had heard that an early diagnosis, however, by a competent doctor of a patient, with all the means that we now have available, would detect cancer or would probably or possibly detect cancer in its early stages, and that, if detected in its early stages, there was a possibility of cure. Is that correct?

Dr. GOIN. That is quite true.

Senator Pepper. Well, then, the early adequate and thorough examination by a competent doctor, with the use of proper equipment, would be conducive to the detection of cancer and, therefore, probably have the effect of preventing many deaths which could otherwise occur from cancer, wouldn't it?

Dr. Goin. I wish that were true, but the fact is that cancer of the stomach, for example, is one of the greatest killers of men as distinguished from women. Cancer of the stomach is a silent disease. It presents no symptom at all that everyone of us haven't had at frequent occasions, namely, a little indigestion. Shall every person with a little indigestion go to a doctor? Who shall pay for it? Where shall we get the personnel to do it? Shall a doctor do it in his office when he isn't competent?

Senator Pepper. What would you suggest we do about it?

Dr. Goin. I think you are perhaps as unprepared to do it as anybody.

Senator Pepper. What is the reason for our lack of preparedness to do it?

Dr. Goin. We simply don't have the skilled personnel. It costs too much.

Senator Pepper. Are the dollars that it would cost worth more than the lives that it would cost, Doctor?

Dr. Goin. That is a question you would have to ask yourself.

Senator Pepper. I guess if the question were put to a cancer patient, he would rather save his life instead of the dollars.

Dr. Goin. That is right. Let me tell you that a test run of a survey method of detecting cancer such as is now provided for tuberculosis was run on 800 presumably healthy adults. Now that is where you will have to find it. It is no good finding it after the person has obviously got it. Now the test run on the 800 adults yielded 2 cancers of the stomach. On that basis, can we do it? As a matter of fact, every one of us would have to have an examination every 6 months.

Senator Pepper. What would be the alternative to our not doing it, Doctor?

Dr. Goin. I don't know.

Senator Pepper. Well, the people would die, wouldn't they?

Dr. Goin. That is right.

Senator Pepper. Well, isn't that a challenging enough problem to us to make us exert ourselves, and should we be deterred by the expenditure of an even larger sum of money to save the lives of one out of eight of our people?

Dr. Goin. Not one out of eight. Two out of 800.

Senator Pepper. I understand from a lot of current statistics that about one out of eight living people would die from cancer.

Dr. Goin. I was speaking of cancer of the stomach.

Senator Pepper. Oh, I see. Well, these other cancers can be detected more easily than cancer of the stomach?

Dr. Goin. Yes. It varies all the way from very easy to extremely difficult, if not impossible. I think a great deal of thinking about cancer is confused by the failure to recognize the fact that cancer isn't a disease. It is a name loosely applied to a whole lot of diseases, and they vary a great deal. They vary in the ease of diagnosis. For example, cancer of the skin is very common in the face of the aged. It is a rather simple disease. It never kills anyone. It makes it an unsightly and disagreeable sore. It has no tendency to spread and, practically speaking, no one ever dies of it. You can go from that extreme to cirrhosis of the liver from which, if you are lucky, you will live 6 weeks; if you are unlucky, you won't live that long.

Senator PEPPER. I think everyone recognizes it is a very complex problem, but is it your opinion and the consensus of the profession that an early examination by a competent authority, with adequate equipment, will be conducive to discovery which will aid in the saving of lives?

Dr. GOIN. That is right; but I am trying to point out that there is no practical method prepared of doing that.

Senator PEPPER. What is required, Doctor, to make those examinations?

Dr. GOIN. If you are going to find early cancer of the stomach, you must have highly trained and highly competent experts with adequate X-ray equipment.

Senator PEPPER. Well, couldn't we train a great many of these people to do that? Couldn't we manufacture all the X-ray equipment and install it somewhere?

Dr. GOIN. Oh, we have the X-ray equipment. We don't have the people to operate it.

Senator PEPPER. If we do have adequate X-ray equipment and people aren't getting the examination they need because we don't have adequate personnel, do you think we are doing all we can to train personnel that would save the lives of people?

Dr. GOIN. There is a problem there, too. The armed forces put out a survey during the last part of the war in which they inquired what the medical veterans would like to do. When they got through, a great many of them expressed a desire for residencies in various things, among them residencies in radiology. A survey made of the facilities indicated that there were 300 places available in the country where residencies in radiology could be had, but there were 2,000 or 3,000 people who wanted them. So with a backbreaking effort, the number of residencies was increased to 581.

Senator PEPPER. What do you mean by residencies?

Dr. GOIN. That is a place where a man can be trained in this sort of thing.

Senator PEPPER. Isn't there some way that we can establish more residencies somewhere?

Dr. GOIN. You can build 1,500 more hospitals and equip them with 1,500 more men qualified to teach.

Senator PEPPER. We could build the hospitals, couldn't we, if we had the men?

Dr. GOIN. I suppose so.

Senator PEPPER. Fifteen hundred hospitals wouldn't challenge the productive capacity of the United States very seriously. How many men would have to be trained to man those hospitals?

Dr. GOIN. You would have to have 1,500 men trained to teach.

Senator PEPPER. Have you any suggestions?

Dr. GOIN. No; I haven't.

Senator SMITH. Isn't that an evolutionary process?

Dr. GOIN. It is, indeed. I would like to make one remark, that one often doesn't know the right answer to a problem but infrequently is in difficulty to recognize a wrong, and it is a fallacy to think you must be able to give the right answer before you are qualified to say that the wrong answer is wrong.

Senator PEPPER. Excuse me, Doctor. We have, however, a venereal disease treatment program, and we have by the tuberculosis inspection program which is under way detected many cases of tuberculosis and made treatment available by public aid, haven't we?

Dr. GOIN. That is right.

Senator PEPPER. And probably the adequacy and the competency of the program will have a great deal to do with the solution of these problems, will it not, and if the program is inadequate and the planning, of course, inefficient, the execution incompentent, why, of course, we will have less results, but I suspect that it boils down to a question of just how determined you are to meet the challenge of these problems which are taking daily and hourly the lives of our people. Thank you very much.

Senator SMITH. Of course, Senator, I might add that there are many other things taking the lives of our people. We have these sudden airplane disasters that kill a number people at once. I agree with you that if we had some way of avoiding them, we would certainly utilize it, but we have to rely, it seems to me, on the evolutionary method of trial and error in making progress. There is no country that has made greater progress than the United States. We are making progress in our cancer research, and my feeling is it can't be done by taxing everybody. You can't buy certain types of things. You have to progress by experience. That is the feeling I have. It seems to me it is not a practicable thing to say we can just build so many hospitals and educate so many men and we can just cure cancer by such a route. I may be wrong.

Dr. GOIN. If I can make my next two remarks, I think they will add to what I think you will want to say. We are speaking now of preventive medicine, and I have just pointed out that its confidence is somewhat overgrown, but I think we might like to know what preventive medicine was going to be provided by the last—as I say, I haven't had time to read the compulsary insurance bill, but what did the last one propose for preventive medicine? I think it is of interest to note just what it did propose.

In the last bill there were two references—I am referring to the Murray-Wagner-Dingell bill of the last Congress. One authorized grants-in-aid to research institutions, and the other directs that the administration of the law shall be such as to prevent accident, disease, and premature death. A consummation devoutly to be wished for, but a typical example of the type of thinking that leads to compulsory health insurance, i. e., write it down in a law and it is accomplished. That was in the last compulsory insurance bill.

Senator PEPPER. Doctor, we people here in Congress don't have much of anything we can do except to provide the money from the wealth of this country and to give the authority that may be necessary to carry out the program. We largely have to rely upon technical people to come and tell us that one out of every eight of our citizens now living is going to die with cancer and, for God's sake, can't you people here in Congress provide all the money we technicians can use and all the authority we can properly discharge to try to save that 17,000,000 of our population? The thing that shocked some of us here, and we have the right individuals to be shocked—I am not going to suggest that the whole committee is going to be shocked at the same time, but I am individually shocked. I have been here now nearly 11 years and I never have heard many technicians come in here and make an appeal to this Congress, that "Gentlemen, if you will make the funds available to us we will build some more medical schools, we will give more scholarships, we will give more loan funds to deserving boys and girls who will make technicians, and we will establish better training courses. We will build more hospitals and we will save a few more of these people by detecting this cancer." and so forth. But it is the laymen who makes the appeal.

I must say to you, Doctor, it is my observation that it is the layman who, seeing these things, is the fellow that pushes and drives. Maybe our plans will have defects and they will have to be worked out in time, but we prefer to go down trying and fighting rather than to be so hesitant and reluctant, and if we are going to wait, a few more million will die before we seriously undertake to do anything. That is an all-out attack on this problem. So when you are weighing the disadvantages of these more aggressive approaches, I think you have to appraise the disadvantages of this quite tardy pace that is suggested as an alternative.

Dr. Goin. I don't think, Senator, that anyone wants to suggest so tardy a pace. I think it is merely those of us who have some reasonably expert knowledge of the problem don't believe it is quite so simple as those who just look at it as outsiders.

Senator Pepper. How much of a solution of the health problem is going to be provided by the Taft bill which provides $200,000,000 in aid? How many more technicians is it going to train? How many more facilities is it going to open up? How many more people will it make medical care available to in relation to the need? That is what I am getting at.

Sure, that's good; a dollar and eighty cents would help, but the $200,000,000 and the grants-in-aid, the what I call charity program, the means test scheme of the Taft bill, is that going to meet the medical needs of the people of the United States to the extent that it is properly possible to do it? That is the question. Sure, it will do good, but the question is: Is it all that we can and should do?

Dr. Goin. My mathematics breaks up at long division and I am considerably confused by the technical section of the bill as it apportions this money, but as I understand it, it is not $200,000,000, but it is $200,000,000 to be matched by the States, which will make it a considerably greater sum of money than $200,000,000.

Senator Pepper. That is right, but the States can get credit for what they are spending already, so the amount of new money is not going to be the equal of this money.

Senator Smith. A billion dollars in 5 years to see where we can go from there. It is the trial and error method, but it isn't aimed to be an answer to the whole health problem of the United States. It is simply trying to meet the most immediate and pressing needs and stimulate the States to do their investigating work and see where we can go. I don't think it is fair to compare the $200,000,000 to the $10,000,000,000 that the Murray-Wagner-Dingell bill calls for when you don't know where to spend the $10,000,000,000. We are trying to make a step in the right direction.

We had testifying this morning doctors from the State of New Jersey who feel they have a program. It does meet the needs of their people. We are not denying the continuing research in cancer, but we are saying it should be done by doctors like yourself who know what has to be done for progressive research in cancer and not be flying around in a way that it wouldn't be effective.

Dr. GOIN. We think we have such a program, too, as I will tell you in a moment. Now returning to these voluntary health-care plans——

Senator PEPPER. Excuse me, Doctor. What coverage do you give under your plan?

Dr. GOIN. In general, or in this specific instance?

Senator PEPPER. I thought you were talking about the California plan, the California Physicians' Plan.

Dr. GOIN. Yes, sir. In just a moment I will explain in its entirety what we do offer. What have the voluntary plans to offer? Service varying from almost complete—i. e., two visits deductible—to that covering only catastrophic illnesses. Not everyone has need of the same amount of service; the voluntary plans afford to each the chance to select that which he requires. Over 70 voluntary plans are now in effect, not including the large amount of indemnity sickness and accident insurance which is written annually by the commercial companies.

I think the committee might like to know that just within the past few weeks the service has been approved by the Southern Pacific Railway. The Southern Pacific Railway has a plan of its own for its employees. It furnishes them the hospital and medical care but not for their dependents.

Senator PEPPER. Is that a voluntary plan or is that a requirement that they join?

Dr. GOIN. I wouldn't know.

Senator PEPPER. But the amount is payable from deductions from their salary.

Mr. BOWMAN. That is right.

Senator PEPPER. Do you know what the percentage is?

Mr. BOWMAN. They have 100-percent group participation.

Senator PEPPER. Then it is not voluntary altogether if you get a 100-percent group participation.

Mr. BOWMAN. There is a certain amount of compulsion.

Senator PEPPER. Now that is a railroad that does have a compulsory insurance plan for its people.

Mr. BOWMAN. But the employees are running that themselves, Senator.

Senator PEPPER. But as far as the workers are concerned, it is a compulsory requirement of the company.

Mr. BOWMAN. Yes.

Senator PEPPER. Do you know what the percentage or amount deducted is?

Mr. BOWMAN. Around three and a half to four dollars a month for the employee.

Senator PEPPER. Do you know whether that is on a percentage-of-income basis or not?

Mr. BOWMAN. No; that is a flat charge.

Senator PEPPER. Thank you very much.

Dr. Goin. This plan does not cover the dependents of these people, and they have come to the California Physicians' Service and asked us whether we can offer coverage to the 60,000 dependents of these people. We think we can and are now considering how best to do it. Incidentally, we also have offered the American Legion in California a plan in which the members and their families may be covered.

Now, these plans offer their insured the opportunity to select the doctor of their choice, to go to the hospital which is preferred, and, in general, to receive medical care of like quality and under the conditions to which they are accustomed. No administrative officer intervenes; no permits are needed; the relationship between doctor and patient remains the personal and confidential one of the past. No panels are formed; no one's permission is needed to choose a doctor or to change doctors if the patient is dissatisfied. That compulsory sickness insurance can or will permit these freedoms is simply not true.

That voluntary plans can do so, and do so, is shown by the experience of California Physicians' Service. It is difficult to conceive that its astonishing growth, from 40,000 beneficiary members in 1940 to about 500,000 in 1947, could have occurred unless the members were well satisfied with the services thev have received. That they are, in fact, well pleased, is shown by the very small cancellation rate averaging about 2.5 percent. The growth rate of California Physicians' Service is rapid, and is gaining velocity constantly.

With the cooperation of the California State Grange the service has enrolled 13,000 farmers of California representing about 60 percent of the Grange membership, giving them service for surgical operations, specifically including fractures and dislocations and including hospitalization. After 1 year's experience, we are reexamining the contracts with a view to including medical care (as distinguished from surgical care) while hospitalized, and we hope eventually to offer full coverage to these farmers and their families.

The success of this program may be estimated from the following quotations from a letter signed by Mr. George Sehlmeyer, master of the California State Grange:

> As you know, this program has attracted national attention. It is our belief the Grange C. P. S. cooperative program can be built into one of the largest and most satisfactory voluntary health services in the United States.
>
> Through this program, we have been able to make available to our membership surgical care and hospitalization at prices which they can afford to pay. We consider this plan one of the most sound and constructive movements in voluntary health programs.

This represents our first attempt to give service to individuals who are not employees of a common employer, and who cannot be subjected to pay-roll deduction. It is earnestly hoped that this effort will lead to the development of experience sufficient to warrant the coverage of other nonemployed persons.

Recently the service has enrolled 16,000 employees of Standard Oil Co., of California; employees scattered over the entire State, and in increasing numbers employers are hastening to secure this health care service for their employees.

Based on our present experience, we are able to supply surgical care including hospitalization and specifically including fractures and dislocations—I mention that because otherwise surgery generally consists of a cutting operation; so this contract specifically names dislocations—at the following rates: Male employee $2 per month, female employee $2.65 per month, employee and one family member $4.90 per month, employee and two or more family members (including any number of dependents) $6.80 per month.

Senator Pepper. What does that cover, Doctor?

Dr. Goin. It covers all surgical illnesses, fractures, dislocations, and hospitalization.

Senator Pepper. Does that hospitalization include room and medicines and everything?

Dr. Goin. Yes.

Senator Pepper. It does not include medical care in the hospital or medical care in the home, or does it include nursing care in the hospital?

Dr. Goin. Yes.

Senator Pepper. It does include nursing care?

Dr. Goin. Yes. Practically complete coverage, representing all medical care except the first two visits to the doctor, and including hospitalization is supplied at the following rates: Male employees $3.15, female employee $3.80 monthly, employee and one family member $6.05, employee and two or more family members (including any number of dependents) $7.95 monthly. This is almost complete medical care. We have found is necessary to impose upon the beneficiary a charge for the first two visits to the doctor simply because, human nature being what it is, people simply might impose upon any such plan.

For instance, under our present method of giving medical care, John Jones drinks a lot of gin on Saturday night and wakes up with an awful bad headache on Sunday morning. If he just takes a cold cloth and puts it on his head, he will be all right, but if he had a doctor available, we know he would call him. But we don't believe it can be argued that this can be a very serious obstacle to getting medical care. If the first visit to the doctor calls for surgical care, it is also included, as are also X-ray and laboratory work, regardless of whether it is a first visit or not.

Senator Pepper. That hospitalization you provide is only hospitalization in connection with surgery, isn't it?

Dr. Goin. Not under these contracts. Under these contracts, it is full coverage. The only responsibility the subscriber has is that he must pay the doctor the first two times the doctor comes to see him, unless those two visits lead to surgery, in which case he doesn't pay anything.

Senator Pepper. If the patient has pneumonia or something else, he pays.

Dr. Goin. That is right. The only person that says whether he can go to the hospital is his own family doctor. That is all he needs to put him in the hospital. You will note that these latter contracts are practically complete health care services. I would like to remind you again that the last Wagner-Murray-Dingell bill had a charge to the doctor for the first two visits.

It has been found necessary to require the beneficiary to pay for the first two visits to the doctor to discourage the perfectly human tendency to abuse the plan. If the first visit or the first two visits to the doctor lead to surgery, these visits also are covered. The service is now considering the possibility of making the beneficiary responsible for only one visit to the doctor.

If it be argued that these subscription fees are high, let me point out that there is thus far no one who knows what these services would cost under compulsory sickness insurance and to remind the committee that the New Zealand compulsory sickness insurance plan operates with a 7.5 percent pay-roll deduction, that it is further subsidized from money taken from the general tax fund and that its cost now equals 2 percent of the national income of New Zealand. I may also remark that in the senate interim committee hearings in the California senate, testimony was given by proponents for compulsory sickness insurance that a pay-roll deduction of between 6.75 and 7.15 percent would be necessary to finance a full coverage program.

Senator PEPPER. Don't you suppose the adequacy of coverage has something to do with the cost? Would you affirm the fact that your plan has as adequate coverage as the New Zealand plan?

Dr. GOIN. I think it is more adequate than the New Zealand plan.

Senator PEPPER. I say the average coverage.

Dr. GOIN. I think it has far better coverage.

Senator PEPPER. Does your plan give coverage in the home?

Dr. GOIN. Certainly it does.

Senator PEPPER. Maybe I haven't yet got what your comprehensive plan is. I thought you said a while ago you gave hospital coverage, you gave surgical coverage, and you gave coverage for fractures.

Dr. GOIN. We have two types of coverage. The subscriber may elect whichever coverage he wishes. We have the so-called catastrophic illness coverage. That is the simplest and cheapest. That includes surgery of any kind, including fractures and dislocations and hospital care.

Senator PEPPER. How much do you have to pay for that a month?

Dr. GOIN. A male employee, $2, and a female employee, $2.65. We also have the two visits deductible, and except for the first two visits to the doctor, the subscriber is completely covered against any kind of medical care whatever.

Senator PEPPER. How much is that?

Dr. GOIN. Before I tell you that, if the first two visits for which he is responsible lead to surgery, they are included. So that if the doctor came to see Mr. Jones and he had a red-hot appendix and took him to the hospital, Mr. Jones would not have to pay for the doctor's visit. Also, the first two visits include all laboratory and X-ray services, regardless of whether it is a first visit or not. So the only thing a subscriber has to pay is the doctor's fee for two home or office visits, unless it leads to surgery. Now the cost of that is $3.15 for a male employee and $3.80 for a female employee.

Senator PEPPER. You mean the only people covered by this program are employees of a given employer?

Dr. GOIN. The only persons who have the complete coverage are the actual subscribers themselves.

Senator PEPPER. But they have to be part of a group of employees working for a given employer.

Dr. GOIN. Thus far they do, although we are about to extend it to the Grange.

Senator PEPPER. You mean that is as far as you have gone so far?

Dr. GOIN. Yes.

Senator PEPPER. Does that include any dental care?

Dr. GOIN. No.

Senator PEPPER. Does it include any nurse who might attend the patient in the home?

Dr. GOIN. No.

Senator PEPPER. Does it include the cost of a physical examination if a patient subscriber wanted to get a check-up, X-rays, and the other services you get when you get a general check-up?

Mr. BOWMAN. For diagnostic purposes; yes.

Senator PEPPER. I am speaking if he wanted to go down to the doctor or the hospital and get a general check-up.

Mr. BOWMAN. General physical examinations are not included.

Senator PEPPER. I see. Now, does that include the subscriber and his dependents or just the subscriber?

Dr. GOIN. The full medical-care benefits are just for the subscriber. The dependents are covered in the surgical-catastrophic contract.

Senator PEPPER. Would you say that the average income of those employees you referred to is in excess of $150 a month?

Dr. GOIN. Yes; I should think so.

Senator PEPPER. Would you suppose it exceeds $200?

Dr. GOIN. No; probably not. I think something like 54 percent of the people in California earn a little over $2,000 a year.

Senator PEPPER. I was asking that, Doctor, to make a comparison in the cost of your plan and in the Murray bill plan. Under the Murray bill plan, if a person made $200 a month, he would pay 1½ percent, the worked himself would pay 1½ percent, which would be $3 a month, and then the employer would pay 1½ percent, and that would include all the coverage that is provided in this bill, and in addition to that, it would cover the dependent of the worker. So that, if it could be done that way, from the viewpoint of the individual worker, it would be cheaper.

Dr. GOIN. Does the new Murray bill specify 1½ percent? Of course, the last one did not.

Senator PEPPER. I think it contemplates 3 percent.

Dr. GOIN. This current bill names the percentage of pay-roll deduction.

Senator PEPPER. I believe it is 3 percent of pay-roll or 3 percent of the income of a self-employed person up to $3,600 a year.

Dr. GOIN. Was that figure just selected at random or is there some basis for that?

Senator PEPPER. It is my information that that figure was arrived at after a long study of the subject by the Social Security Agency here, the Public Health Service, and by many other people. In addition, I don't want to try to suggest the concealment of the fact that the bill does also provide that any deficiency above that rate of paymen would be provided for, as the Taft bill provides, by a Federal contribution. Now, how much it would cost the taxpayers, of course, I don't suppose anybody can know for sure until there has been some experience with it. However, as far as the employee is concerned, that is the amount that he would, under this bill, have to pay.

Dr. GOIN. I think that is very interesting. Two years ago, our Governor introduced a compulsory health-insurance bill in the California Legislature, and among his experts, he had Prof. Samuel Mays, who is professor of economics at the University of California, who covered a blackboard as big as that wall, showing where it couldn't possibly cost more than 3 percent, but at the Senate interim hearings last summer, the same proponents testified that it would cost between 6.75 and 7.15 percent, a slight reversal of their opinion. You will note that it cost a great deal more than that in New Zealand. As a matter of fact, it cost 2 percent of the national income.

I was also interested in hearing Senator Murray a few minutes ago say one of the things he objected to most was the fact that people were embarrassed to ask for medical care on the basis of charity. I wonder what it is when the employer pays part of the premium as compelled by law. I am an employer. What am I doing when the law compels me to pay part of my employee's health care? Isn't that charity?

Senator PEPPER. No, I wouldn't call that charity. I would call that a required contribution to the public welfare. [Laughter.]

Dr. GOIN. In conclusion, I say again that voluntary health insurance will give to the American people more medical care and much better medical care than can ever be furnished by a politically managed compulsory plan. Particularly is this true if the States are permitted, or assisted, in the subsidization of this care for those who are actually unable to afford it.

I would like to point out that no compulsory insurance bill that I have ever seen makes the slightest provision for the indigent.

Senator PEPPER. If I may say so, have you had a chance to see this bill, Doctor?

Dr. GOIN. No; I haven't.

Senator PEPPER. It is my understanding that this bill contemplates, as does the Taft bill, that if this compulsory insurance plan were in effect for the indigent people, the Federal Government would assist the States and local subsivisions in paying the required contributions. Just as under the Taft bill, part of the money may be used to pay the money into the fund that would be required to be contributed by the indigent person in a voluntary system. In other words, under the Taft bill, an indigent person could be enrolled in your system and the fee required be paid out of these funds. Now the same provision, in substance, as I understand it, is carried in the Murray bill. It contemplates that the people who don't have income, who are actually in the indigent class, could have their contribution paid for them out of public funds.

Dr. GOIN. That the growth of voluntary health-care plans has been slow is to be expected. Evolution is a slower and less dramatic process than revolution but the evolutionary product is likely to be the sounder one. Voluntary health care plans are being developed and as rapidly as may be. Actually more than 70 are now in existence in almost all of the States. These have been developed on sound actuarial bases by men who know that the complex and vexing problems of medical care are not to be solved by writing words and making them into laws. With the few reservations previously mentioned, I thoroughly commend this bill and trust that it will be enacted into law.

Senator SMITH. I understand that Dr. Cahal has submitted a statement to accompany your statement. I want to make a note that the statement of Dr. Cahal will be accepted for the record, if that is your desire.

Dr. GOIN. Yes.

(The brief of Dr. Cahal is as follows:)

STATEMENT BY THE AMERICAN COLLEGE OF RADIOLOGY (NATIONAL ASSOCIATION OF MEDICAL SPECIALISTS IN X-RAY AND RADIUM), SUBMITTED BY MAC F. CAHAL, J. D., EXECUTIVE SECRETARY AND GENERAL COUNSEL, AMERICAN COLLEGE OF RADIOLOGY

The American College of Radiology is a national association of medical specialists in X-ray and radium. It is one of many national organizations composed of specialists in a particular branch of medicine.

Of the 2,370 physicians who have been certified as qualified specialists in radiology, 1,817 are members or fellows of the American College of Radiology. The three other radiological societies which are national in scope are represented by the American College of Radiology by virtue of official representatives of the respective societies who sit on its board of chancellors.

While not officially affiliated with the American Medical Association, the college is closely associated with it. The policies adopted and expressed by the college are almost invariably in accord with those of the American Medical Association. Membership in the American Medical Association is a prerequisite to membership in the American College of Radiology for residents of the United States. Headquarters of the college are in Chicago.

My name is Mac F. Cahal. I am executive secretary and general counsel of the American College of Radiology and a member of the Illinois bar.

For myself, and on behalf of the American College of Radiology, I appear here to speak in favor of Senate bill 545, the National Health Act. I am in favor of Senate bill 545; I am opposed to Senate bill 1320, the "National Health Insurance and Public Health Act." I frankly acknowledge my convictions, and I will freely lay before you the reasons on which they are founded.

Arnold Toynbee, in his much-talked-of study of history, shows that the 21 civilized societies that have arisen since the dawn of history have flourished and survived or decayed and died according as they have responded to challenges from within or without. Most challenges that have threatened the survival of these societies have come from without. But a society can be threatened from within.

I believe that the threat of compulsion in the name of security is such a challenge to our society. I believe that the people of the United States will continue to enjoy the fruits of liberty and democracy, with ascending spiritual and economic rewards, only if they shun the Circean temptation of governmental paternalism and follow the route of self-determination, with freedom of initiative, freedom of opportunity, and freedom of enterprise. I believe our society will respond ignobly and the civilization our fathers erected here will have passed its zenith if the responsibility for one of the necessities of living—and medical care ranks with food, shelter, and clothing as a necessity—is shifted for all the people from the individual to Government.

At the same time, I do recognize that there are some people, less fortunate than others, to whom society must offer financial help in order that they may provide themselves with essential goods and services. An obligation to the unfortunate has always been recognized by the American people. This obligation has been performed either through private charity or tax-supported welfare services. Senate bill 545, consistent with this principle, proposes to offer financial help to families which, on occasion, may lack the funds required to purchase needed medical or hospital services.

Some of the critics of the Taft-Smith-Ball-Donnell bill have opposed it on the grounds that it was charity. What has happened in our country that the word "charity" should have acquired an ugly connotation The vigor, strength, and genius of America has blossomed in a soil nurtured by the Christian tenets of faith, hope, and charity. And the greatest of these is charity.

Instead of using tax funds to help those who need financial help, the critics of this bill would compel everyone, regardless of need, to accept medical services from the Government, purchased from a tax fund of enormous proportions. Should the prerogatives of all the citizens be surrendered to Government because some of the citizens, when victims of long or expensive illness, are legitimate objects of charity?

No one disputes the fact that relief of distress and financial aid to the needy is a legitimate function fo Government under the general welfare clause. Neither is there any disagreement over the fact that families of low income are sometimes unable, without outside help, to purchase all the medical service they may need in a given year. Senate bill 545, I believe, is a sound and proper approach to this problem.

The reasons for the objection of the medical profession to the adoption of compulsory sickness insurance for all the people were fully set forth before the predecessor of this committee last year during hearings on the Wagner-Murray-Dingell bill. It would serve no useful purpose to repeat them here. The important point is that the present bill meets the only real problem in such a manner as to elicit the support and approval of the medical profession. The doctors of America will gladly participate in a Government program of this nature. The vast majority of them would probably be unwilling to participate in a compulsory system such as that called for in last year's bill or the current Senate bill 1320.

The integration of all the scattered activities of the Government in the field of health into a single national health agency under a properly qualified administrator, provided for in title I, is so laudable as to be beyond controversy. Previous witnesses, particularly those representing the American Medical Association, have set forth the reasons why this would greatly improve the present situation.

Particularly desirable is the provision contained in the bill for determination of needs and administration of the actual program on a State level. Cogent evidence is available to prove that needs and conditions vary in different States and in different communities. One of the chief objections of the medical profession to previous national health bills has been on the ground that a single national program, federally administered, would disregard varying conditions in local communities. Under State control differences in needs, costs, and income levels may be taken into consideration and different methods employed.

During the course of these hearings several amendments to the bill under consideration have been proposed. Several suggestions occur to me which, I believe, would improve the proposed act. With the exception of two, however, most of these are of relatively minor importance.

I disapprove of the provisions of section 203 of title II of the proposed act, relating to cancer. Here I take the liberty of discussing one of the two suggestions which I offer in the belief that their adoption would improve the bill. The opinions of specialists in radiology, whom I represent, should be particularly valuable on this subject because a large part of their work is devoted to the diagnosis and treatment of and research in cancer.

This section would authorize the appropriation of $10,000,000 annually for "the prevention and control" of cancer. Cancer is only one of the diseases which afflict mankind. Is there any sound reason for singling this particular disease out for special appropriations in a bill providing for general medical, hospital, and dental care for needy families? Just as much reason exists for special grants for the "prevention and control" of cardio-vascular disease, arthritis, gastric ulcers. or a dozen other disease entities. Cancer is not a communicable disease; it is neither subject to prevention nor control. Persons suffering from cancer, exactly as is the case with all other noncommunicable diseases, need only services that will result in a proper diagnosis and competent treatment. These services are fully provided for in section 204 of title II providing for grants-in-aid to assist States in providing health service for families and individuals with low income. Adequate facilities are available to these and all above this economic level for early diagnosis and proper treatment of cancer.

Section 203 of the bill is proposed "to enable the Surgeon General to carry out the purposes of section 301" of the Public Health Service Act, relating to research. Presumably, therefore, these funds would be used entirely for research. Even so, there is considerable question that such an expenditure is wise or necessary. There is a limit to the amount of money that can be spent productively in scientific research. Some of our leading research workers in cancer are of the opinion that funds available from private sources are today more than adequate to support effective research in the cause and cure of cancer.

Part A of the proposed new title VII of the Public Health Service Act, called for in title II of the bill, would seem to raise no questions for debate. A survey and inventory of existing medical, surgical, and hospital care is obviously an essential preliminary to the establishment of a State program for assistance to persons of low income. It seems to me, however, that the second sentence of section 701 should make it clear that grants from the $3,000,000 fund provided in this section are to be used for the making of the surveys called for in section 712 (a) (7) and not as the bill now reads to assist the States "in carrying out the purposes of section 711." This latter section is the one providing for the appropriation of funds to assist in the actual provision of health services; separate appropriations are authorized for this purpose.

My second suggestion for amendment of the bill refers to that provision in section 712 (a) (4) permitting States to use the funds created under the bill for the payment of premiums or partial premiums for low-income families to any voluntary insurance fund, *operated not for profit.*

The main feature of this provisions is excellent. The authors of the bill have hit upon a thoroughly sensible way of using tax funds to assist persons of low income in obtaining needed health services. What better method than to utilize existing insurance plans which will guarantee to pay the costs of medical and hospital services when the need arises? It is ideal.

The families and individuals referred to in this section as "having insufficient income to pay the whole cost" of needed medical and hospital services are those whom the medical profession has come to call the "medically indigent." By this we mean those people who have sufficient income to purchase the ordinary necessities essential for adequate food, shelter, clothing, and health but who may encounter sickness of such severity or duration that the costs will exceed their ability to pay. They are not indigent; they can provide themselves with all the necessities, including ordinary medical care. But occasionally a series of illnesses in one family or a particularly expensive series of diagnostic or therapeutic procedures in one illness will incur a cost beyond their means.

Thus, the need for financial assistance during sickness does not occur in a well-defined economic class or income group. Medical indigency is not a status; it is an occasion. How ideal, then, is the utilization of voluntary insurance plans to provide benefits for persons who would otherwise need financial assistance during sickness.

Under these conditions a State program may use funds appropriated under the act in two ways. First, it can pay the full premium for medical, surgical, and hospital benefits for persons who are truly indigent, i. e., those whose financial state is such that they can pay no part of such premiums. For the group above this minimum but below a certain maximum income (the medically indigent) the individual would pay a portion of the premium, the balance being made up from the State fund. When the insured event occurs (sickness) the individual would receive benefits from the voluntary carrier just as if he had paid the full premium himself.

Second, persons above these income limits who have not privately purchased insurance may require financial assistance in the event of a catastrophic illness. Such individuals, when certified by the State welfare agency, would receive outright assistance grants to supplement the amount they were able to pay from current income and savings.

My objection to this section is to the requirement that these funds may be used for the payment of premiums only to not-for-profit insurance plans. Why, if they can furnish the benefits on a comparable basis, should not private voluntary insurance companies be permitted to receive these funds? These companies are already subject to the scrutiny and control of the respective State governments through their insurance commissioners. If they can successfully compete with nonprofit cooperatives, then I believe they should be permitted to do so.

Senate bill 545 is a splendidly conceived method for relieving the needy of the burden of unexpected and expensive sickness without destroying the fabric of our system of political economy which recognizes the merits of freedom of enterprise and private initiative. The private status of physicians, dentists, and hospitals will be left unchanged. A beneficiary of the act needing expensive drugs or appliances will presumably be given financial assistance that will enable him to purchase them from a retail purveyor of these commodities. Suppose a physician, after examining a patient suffering from chronic anemia, prescribes extra quantities of fresh meat. Suppose this addition to the food budget is beyond the patient's means. Presumably, he will receive additional funds to permit him to buy the supplementary foods he needs from his grocer or butcher. It is not required that the druggist or grocer operate his business not for profit. Why should we not follow the same principle in purchasing sickness insurance for these people? What about freedom of enterprise in the insurance business?

Private insurance companies today provide life insurance to cover 75,000,000 Americans. Something like 44,000,000 are protected against certain medical costs and accidents under policies backed by insurance companies. Perhaps they can furnish benefits under the State programs prescribed in section 711 better than a cooperative plan operated not for profit. I believe Senate bill 545, to be consistent, should give them the opportunity.

Proof that regular insurance companies can perform this function is to be found in the experience in California under that State's nonoccupational disability law. Under the California law an employer may use private insurance carriers or the State fund for coverage of his employees. Despite the fact that 75 percent of the employees in a plant must vote in favor of a private carrier as against the State fund, over 500,000 employees in 7,000 industrial groups have been covered by voluntary company plans since December 1, 1946, when the act became effective. This represents 22 percent of the eligible labor force.

It is true that nonprofit plans, sponsored by hospitals and medical societies, have filled a valuable function. Today nearly 25,000,000 are enrolled in nonprofit hospital insurance plans. In the few years since they were created medical- and surgical-care insurance plans have enrolled approximately 5,000,000 subscribers. Sixty-four nonprofit medical or surgical insurance plans are now offering coverage in 37 States. The recognition of these plans and the support given them in the bill is commendatory. But, there seems to be no good reason why regularly approved insurance companies should not be given the opportunity to participate under the proposed act.

There are advantages and disadvantages to both the commercial insurance and the nonprofit plans. A discussion of these would take longer than the time available to me here; it must wait another time.

With these suggestions for the consideration of the committee I wish to express my endorsement of Senate bill 545. I regard it as far superior to any other proposal heretofore made to the Congress for improvement of the Nation's health. It is voluntary, it provides for local determination and administration, it offers help where help is needed without demanding a revolutionary change in the American system of medical practice.

If it is necessary that the Federal Government appropriate tax funds for medical care, a matter concerning which I am not entirely persuaded, the present bill represents a sound and intelligent method for the accomplishment of the objective sought.

Senator Pepper. I have been handed a statement here which purports to particularize the services afforded under the New Zealand system and it lists treatment by general practitioners, home, office, hospitalization, treatment in the out-patient department of the public hospital, maternity care—prenatal, confinement, postnatal—drugs, medicines prescribed by a physician, X-rays, diagnostic services, physiotherapy, and visting nurse. This is some data on the New Zealand system which I would like to incorporate in the record.

(The New Zealand data submitted by Senator Pepper is as follows:)

## The New Zealand Health Benefits Program

### *What it is*

Makes the following services available to all residents of New Zealand on a free basis and for as often and as long as the need for the service is indicated:

Treatment by a general practitioner in home or office.
Hospitalization.
Treatment in the out-patient department of a public hospital.
Maternity care (prenatal, confinement, postnatal).
Drugs, medicines, appliances, or materials prescribed by a physician.
X-ray diagnostic service.
Physiotherapy.
Visiting nurse service.

Benefits are administered by the health department. Payment to the physician, hospital, nurse, pharmacist, and technician is made by the Social Security Department from the social-security fund on the basis of a fixed fee per unit of service; in the case of drugs, on the basis of a schedule of fixed prices. Most general practitioners participate on a fee-for-service basis, charging the fee to the fund as a general rule: some charge the patient an additional fee. Some doctors are on capitation and a few on salary. There is free choice of doctor and of patient. The social-security fund receives about three-fourths of its income from an earmarked income tax (5 percent at present; 7½ percent beginning May 1946) and about one-fourth from general revenues. In 1944–45 expenditures for health benefits were £5.2 million, 24 percent of total fund expenditures of £21.7 million. (Cash benefits took £13.5 million.)

Senator SMITH. Thank you very much, Doctor. We appreciate your testimony.

Senator PEPPER. Doctor, I just want to leave you with this commendation. I think all you are doing is fine and it is certainly a step in the direction of better service to the people of the country. I don't mean in any sense to disparage what you are doing.

Before the gentlemen from California leave, Mr. Chairman, while they are here, I want to offer a statement that has just been submitted to me from the American Federation of Labor. It is headed: "C. J. Haggerty, secretary-treasurer of the California State Federation of Labor, telephoned the following statement to AFL headquarters today, denouncing the manner in which the Senate hearings on pending health legislation is being conducted," in which they say that the gentlemen here today do not represent a fair cross section of the sentiment in California and stating that organized labor in California was in favor of the health bill.

Senator SMITH. Which health bill?

Senator PEPPER. That they are in favor of compulsory health insurance and opposed to what they call charity medical care for our self-supporting people. This is their statement.

(The statement submitted by Senator Pepper is as follows:)

[From the American Federation of Labor Information and Publicity Service]

C. J. Haggerty, secretary-treasurer of the California State Federation of Labor, telephoned the following statement to AFL headquarters today, denouncing the manner in which the Senate hearings on pending health legislation is being conducted:

"The chairman of the Senate Subcommittee on Health of the Senate Committee on Labor and Public Welfare has invited witnesses from California to testify before that committee on the merits of the Taft-Ball-Smith bill, S. 545, as against the national health-insurance bill, S. 1320.

"The only Californians invited were representatives of the California Medical Association, the California Physicians' Service, and an assemblyman sponsor of medical society bills.

"We wish to register vigorous protest to this procedure. These people most certainly do not represent the opinions nor the experiences of Californians on the subject before the committee.

"The California Medical Association has earned the reputation in this State of being a lobbying organization willing to engage in the most flagrant violations of good citizenship in its attempts to halt both the march of compulsory health insurance or even the organization by consumers or doctors of comprehensive medical plans which would not be under the domination of the medical trust. Our Governor, Earl Warren, has denounced the political machinations of this organization.

"The California Physicians' Service was originally started with the purpose of halting a movement to provide really comprehensive medical care to the people of this State at rates commensurate with their income and under a system protective of their rights. This monopolistic organization has, since its inception, constantly raised its rates and decreased its services without even a pretense of consulting with the people who have to pay the bills.

"Many of our members do belong to California Physicians' Service and pay its exhorbitant rates for inadequate care, but this is only because we are denied the opportunity of participating in comprehensive plans. It is the CMA and the CPS that is responsible for this denial.

"The few plans in the State which, not being under medical society control, do find it quite possible to offer and do offer complete medical care—such as the

Kaiser plan—were established and are maintained only over the vigorous opposition of organized medicine in this State.

"Mr. Geddes' assembly interim committee is regarded here as nothing more than a pliant tool of the medical monopolists. Its vaunted 'public opinion poll' and its lengthy calculations were anything but objective.

"These groups do not represent California's labor. If further proof is needed, witness the fact that Mr. Geddes is sponsor of a CMA-CPS bill now before our assembly, a bill under which employers can enroll our members in CPS without asking their permission, can pay our money to CPS without our leave. Evidently Mr. Geddes and the CMA-CPS of California do believe in compulsory medical care—but only when they do the compelling.

"Organized labor in California is for compulsory health insurance and opposed to charity medical care for our self-supporting people. Our State senate committee on prepayment medical care—which was not invited to testify—has recommended that our State should establish a State system of health insurance 'at once.' Our Republican Governor, like his Democratic predecessor, has insisted that we need compulsory health insurance.

"These are the views of Californians."

Senator Pepper. Now I have a number of newspaper clippings here headed, "Governor Warren, of California, Calls Insurance Proposal Basic." The headline is: "For Truman Health Plan." There has been we all know quite a bit of discussion in the press of California, and I want to offer that for the record while these gentlemen are here.

(The newspaper clippings submitted by Senator Pepper are as follows:)

[From the Times, New York, N. Y., November 25, 1945]

### For Truman Health Plan—Governor Warren, of California, Calls Insurance Proposal Basic

(Special to the New York Times)

Sacramento, Calif., November 24.—Gov. Earl Warren, whose plan for establishment of a State-wide compulsory program of prepaid medical care was defeated at the last session of the legislature, has commended President Truman's proposal to Congress recommending the setting up of a national system of compulsory health insurance.

Home from meetings of the State council of governments at Chicago and of the western governors' conference at Cheyenne, he described the Truman plan as "not only a health insurance program but a much broader plan designed to build up our educational facilities and our hospital facilities to a place where health insurance can be made effective."

California's Republican Governor added that if and when a national health program were set up, an effort should be made to "conform in the States." Favoring a maximum of local autonomy, he asserted that every State "should have an opportunity to go just as far as it desires, subject to Federal standards, under a Federal act."

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[From the Bee, Sacramento, Calif., January 28, 1947]

### Limited Services Health Insurance Program Is Announced By Warren

By Herbert L. Phillips

Gov. Earl Warren today announced a limited services public health insurance program designed to provide hospitalization, hospital and posthospital medical care and laboratory test coverage for 5,000,000 Californians.

This State system would be financed by a 2 percent pay-roll deduction tax—1 percent each from employer and employee—which would yield, Warren estimated, $125,000,000 a year.

The contributions would be based on the first $3,000 of an employee's salary. The maximum amount of contribution by a worker would be $30 a year.

### 100-DAY HOSPITALIZATION

The bill, which will be introduced immediately in the legislature, would entitle insured Californians to:

(1) Hospitalization up to 100 days for each illness, which the Governor calculated would cover 99 and a fraction percent of all hospital cases. Pregnancy cases would be included.

(2) All medical services incident to hospitalization and subsequent thereto. This would include the services of dentists but only when performing oral surgery.

(3) All laboratory tests made "in accordance with good medical practice," without regard to whether the patient is hospitalized.

The program, Warren stated, would cover all persons now within the unemployment insurance system, and their dependents up to the age of 18; all non-Federal public employees, all self employed, and also the workers of employers not included in the unemployment insurance system whenever such employers choose to come in.

### SALSMAN WILL SPONSOR BILL

This, Warren said, would take in 2,800,000 persons covered by unemployment insurance and 200,000 public employees, with the dependents bringing the total up to 5,000,000 men, women, and children.

The bill will be introduced in both Houses by Senator Byrl Salsman of Santa Clara County and Assemblyman Albert C. Wollenberk of San Francisco.

Warren termed the legislation within the scope of the modified health insurance program recommended recently by the Salsman senate interim committee studying the question.

The State health insurance system would be administered by a director and a State commission, or authority, consisting of three doctors, one dentist, two employers, two employees, and the director of public health.

### COSTS ARE RESTRICTED

Administrative costs would be restricted to 6 percent of the State fund.

The Governor emphasized medical services would be on a "fee for services" basis. The scale of fees would be set by the governing board.

The commission, or authority, would be empowered, the announcement said, to extend the hospital services provided for in the legislation when, in its opinion, facilities and funds are sufficient to include services beyond 100 days.

Likewise the commission also might provide for special nursing services, physiotherapy, material appliances, and for coverage of additional bona fide dependents.

Then Governor Warren listed these four additional types of expanded health services which would be included later only upon legislative enactment at some future session:

(1) Services of general practitioners, physicians, or surgeons, whenever needed for preventive, diagnostic, or other medical services at the doctor's office, in a clinic, or elsewhere—in other words, not limited to care in hospital or to post hospital treatment; (2) services of consultants and specialists outside hospitals in addition to care from general practitioners; (3) dental services; (4) such other services as are deemed necessary "to provide a comprehensive system of medical and dental care."

Tax collecting would start July 1, 1948, and benefit payments would begin January 1, 1949.

### NO CHARITY

Governor Warren explained his position on the program in the following formal statement:

"The purpose of this act is to provide a system of prepaid medical and hospital care through which the people of California will have economic access to medical, laboratory, and hospital services, not as charity but as something that has been individually purchased by them on the insurance principle, without changing the traditional relationship between patient, doctor, and hospital.

"Under its provisions, no system for the dispensing of medical care by the State through doctors employed or designated by the State shall be created. But, on the contrary, it is the express intent that complete freedom of choice by the patient of doctor and hospital, and complete freedom of choice by the doctors and hospitals of their patients, shall be preserved.

### AID VOLUNTARY PLANS

"It is the further intent of this act to encourage and assist the development of voluntary prepaid health and hospital insurance plans and to eliminate them from the provisions of the act, provided they meet the standards of medical and hospital care established for those protected by the act.

"It is the further intention of this act that the system of health insurance created under it shall at all times adhere to the most ethical and professional sandards of the medical profession, and that in order to improve medical practice, all doctors participating in the system be encouraged to keep abreast of the most modern techniques for the prevention and cure of disease through periodical refresher courses at recognized medical schools at the expense of the system."

Warren said any voluntary health care programs which meet the standards of the State proposal could start operating immediately.

### PHILOSOPHY IS UNCHANGED

The Governor expressed the belief his new plan would not interfere with the right of insured workers also to collect benefits under the present sickness and disability law.

Warren said his philosophy on health insurance is unchanged, though his new legislative proposal asks smaller pay-roll contributions than the one defeated by the legislature last session and does not go so far, immediately, in benefit services.

The Governor asserted any description of his bill as "compulsory" health insurance is a misnomer which has "been used by a lot of people for the purpose of discrediting the plan." There is nothing compulsory about it, he declared, except the taxation feature. And he reminded that the income tax, the license fees for doctors and merchants, and all other items of public revenue raising are in the same general category, but never are assailed because of their "compulsory" feature.

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[From the Examiner, San Francisco, Calif., January 29, 1947]

## WARREN OFFERS HIS NEW HEALTH-INSURANCE PLAN—SAME PHILOSOPHY BUT LIMITED SYSTEM WITH PAY-ROLL TAX

EXAMINER BUREAU, SACRAMENTO, January 28.—Details of a proposed new "limited" system of prepaid health insurance providing only for hospitalization and laboratory services were made public today by Gov. Earl Warren.

Administration bills for setting up the new system have been completed and will be handled by Senator Byrl Salsman and Assemblyman Albert C. Wollenberg. The same legislators were authors of the full-scale health insurance bills which were sponsored by the Governor in 1945, and killed in the assembly public health committee.

### OBJECTS TO TERM

Warren said he objected to the word "catastrophic" in describing the type of risk which his new plan insures against. He explained, however, that the program falls within the scope of the interim report recently filed by an interim committee headed by Salsman.

The Salsman report recommended against any attempt at this time to provide full-scale medical care on a prepaid basis, but advocated limited coverage against the "economic catastrophe" so frequently involved by prolonged hospitalization and surgical care.

### PROVISIONS

Warren's new program provides:

1. Hospitalization up to 100 days.
2. All medical services incident to hospitalization.
3. All laboratory tests made in accordance with good medical practice, whether connected with hospitalization or not.

The bills extend coverage to all persons now in the unemployment insurance system. Approximately $125,000,000 a year would be raised by a tax of 1 percent on employer and 1 percent on the employee, up to the first $3,000 a year..

"All those in the unemployment insurance system would be covered, including their families," Warren said. "In addition, the plan would include all non-Federal public employees, all self-employed who choose to come in, and employees not in the unemployment insurance system whose employers provide protection meeting State standards.

"Administration would be in the hands of a director, with policy to be laid down by a commission of three doctors, one dentist, one representative of employers, one of employees, and the State director of public health."

### FIVE MILLION AFFECTED

Warren estimated that 3,000,000 persons would be directly covered, plus an added 2,000,000 dependents.

The bill provides that pay-roll deductions start on July 1, 1948, with operation of the system scheduled to begin January 1, 1949.

The State would continue to deduct the 1 percent now withheld from pay rolls to insure California workers against unemployment due to disability.

The proposed 1 percent for "limited" prepaid hospital care would be an added charge, and the insured individual could collect both benefits simultaneously.

### NO DIFFERENCE

"There is no difference in philosophy between this and the 1945 bill," Governor Warren explained. "Two years ago we offered full medical service right from the start. Now, we propose to limit it to hospitalization and laboratory service, but with the way open for gradual achievement of a full health program."

The purpose of the act, Warren added, is—

"To provide a system of prepaid medical and hospital care through which the people of California will have economic access to medical, laboratory, and hospital services, not as charity but as something that has been individually purchased by them on the insurance principle, without changing the traditional relationship between patient, doctor, and hospital.

"* * * no system for the dispensing of medical care by the State through doctors employed or designated by the State shall be created, but, on the contrary, it is the express intent that complete freedom of choice by the doctors and hospitals of their patients shall be preserved."

Warren said the program would encourage development of so-called voluntary plans.

Participants in any voluntary plan meeting State standards are exempted from contributing to the State system.

A new section in the 1947 bill urges doctors practicing in the State system to keep abreast of modern techniques, and would finance "refresher" courses for them at stated intervals.

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[From the Bee, Sacramento, Calif., December 28, 1946]

## WARREN WILL PRESS FOR BROAD STATE HEALTH AND HOSPITALIZATION PLANS

Gov. Earl Warren today announced a comprehensive program on public health, including a renewal of his fight for public-health insurance, State aid to local districts in public hospital construction, and the establishment of mental-hygiene clinics in Sacramento, Fresno, and other cities.

The recommendations which Warren said he will lay before the legislature convening January 6 include these six major points:

1. Reintroduction of a health-insurance measure having the same prepaid medical service goals as his bill which the last legislature rejected. "If we are to have the public interest at heart, it behooves all of us to put selfishness behind us and strive for means of solving this problem which is perhaps the most basic in the lives of all our people."

### HOSPITAL CONSTRUCTION

2. A State appropriation of $2,000,000 to help local governmental districts in the construction of public hospitals where paying as well as free patients would be treated. Under Federal law, California is entitled to $2,000,000 this coming

year for building hospitals on a matching basis in which local districts would have to put up $2 for every $1 received from the Government. Warren proposes the State shall bear half of the local costs.

3. State payment of an undetermined "basic amount" yearly to every county which will "establish and maintain a full-time health service under standards to be established by the State department of public health."

4. A marked State increase, with a top of $2.50 per patient daily, in tuberculosis subsidies to county health agencies. At present the State pays only $7 a week.

5. Budget provisions to increase the number of doctors, nurses, and attendants at the State mental hospitals "until these institutions compare favorably with the best public hospitals of this character in the country."

### NEW MENTAL CLINICS

6. Establishment of new State mental-hygiene clinics in Sacramento, Fresno, and San Diego, with an additional one in Los Angeles. These would be similar to the Langley Porter Clinic in San Francisco and one approved for Los Angeles by the last legislature.

On the controversial subject of public-health insurance, Governor Warren said the costs of hospital care, rising daily, are now greater in California than in any other State.

"The average is now $12.84 a day—beyond the reach of working people in our State," Warren declared. "Adding doctor bills and other expenses of illness, it drives us to realization of the fact we must have a system of prepaid medical care, based upon the principle of insurance, which will enable every working man and woman in the State to provide adequate medical care for his or her family."

Details of the administration measure will await Warren's receipt of a report from the Salsman senate committee studying this type of legislation.

### ADEQUATE SYSTEM

Stating there is no adequate system of private health insurance to meet the situation, the governor expressed the hope those who have battled public-health insurance in the past "will, instead of blindly fighting, open their minds and try to find some way of accomplishing the desired purpose."

Pledging himself to "intense interest" in health legislation at the coming session, Warren disclosed California is 7,000 hospital beds short of present needs and asserted one-third of the beds now available are substandard or obsolete and should be replaced.

He estimated California needs about 17,000 hospital beds at the present moment—"not just the beds to sleep on but the accompanying hospital facilities for patients."

Citing population gains, Warren also quoted experts as figuring there should be 4½ hospital beds for every 1,000 residents.

In this regard, the executive announced his plan to seek a $2,000,000 appropriation to take over half the cost of local governments this next year in qualifying for Federal hospital construction aid. He favors continuing such State aid for the 10-year life of the Federal program. He said he will urge even larger State allocations if the Federal Government will give more.

### FIFTEEN HOSPITAL DISTRICTS

He listed 15 hospital districts, formed for the purpose of joining in the program, as having been set up in the Sonoma Valley, Paso Robles, Lompoc, Dinuba, Corning (Tehama County), San Andreas, Coalinga, Hemet Valley, Petaluma, Patterson, Sierra Valley, Del Norte, Inyo and Marin Counties, and the Sequoia district in San Mateo County. Others are being formed.

"All of us should work diligently," emphasized Warren, "to see that no one in California is more than 1 hour from a hospital. At present, 26 counties don't have a single sanatorium in them. The rural areas of this State are very decidedly substandard so far as hospital facilities are concerned."

### CITES STATISTICS

Stressing his proposal to "step up very materially the health services in the various counties," the Governor cited these other statistics:

No fewer than 26 counties in California with no full-time health officer. Half of those which do have health officers "afford only a minimum of service."

Complete lack of local public health laboratories in 36 counties. No provisions for public health nursing service in 5 counties. No trained leadership in health education in 53 of the 58 counties.

"These figures," he concluded, "can add up only to a lack of health protection for a large percentage of the people of California. I am satisfied that our program, if adopted, can improve the health standards of the State generally and go a long way toward eliminating communicable and contagious diseases."

### TUBERCULOSIS AID

Governor Warren's intention in aid in control of tuberculosis is to ask an increase of State subsidies to the counties on the basis of $2.50 a day per patient for the first 100 patients in any county; from $1.75 to $2 a day for the next 100; $1.25 a day for all patients over that number.

Until the last legislature, the State was helping only to the extent of $3 a week per patients. That was increased to $7.

This program, geared to give the smaller counties a greater percentage of State aid than the centers of population, also is intended to tie in closely with the proposed development of district hospitals and the expansion of local health services.

"In my opinion," the Governor asserted, "the State should make a very determined effort to eliminate tuberculosis from the life of our people. There are at least 20,000 ambulatory cases of tuberculosis in this State. We are losing 4,000 because of this scourge every year. And the alarming part is that at least one-fifth of these cases are unknown in the health agencies of the State until death has occurred."

### HITS OVERCROWDING

The Government told his news conference he will propose continued and broadened efforts to put an end to overcrowding of the State mental hospitals, increase the services of these institutions, and provide treatment and other services in State clinics "for those whose ailments may eventually take them to the mental hospitals unless cured."

By establishing new clinics in Sacramento, Fresno, San Diego, and Los Angeles, he contended, the State will be able to (1) treat persons before it is necessary for them to become State hospital inmates; (2) release many patients now in the institutions for community life under proper supervision and medical care; (3) save tax dollars for California through disease prevention and better curative methods.

"In a field where the State takes possession of the lives of sick people," Warren commented, "and confines them, when they have done no wrong but are merely ill, it has a very definite responsibility to give them the best care it is possible to get."

Governor Warren repeated the earlier statements of administration officials that because of booming construction costs many additional millions will have to be appropdiated to carry out the $154,000,000 institutional building program voted by the last legislature. He announced he will advocate those additional allowances.

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[From the Times, Los Angeles, Calif., March 27, 1947]

## "Catastrophe" Sickness Insurance

(By Wesley Smith)

"Catastrophe" sickness insurance programs, if they are not to be misleading, should be pointed to their major objective of safeguarding individuals and families from medical care and hospital expenses that can leave financial ruin in their wake.

Existing private plans for assuring the payment of hospital expenses and doctor bills have gone a long way toward providing protection and are increasingly popular. Many progressive employers have instituted protective plans for their employees and in some cases for dependents of employees. All these efforts toward combating one of life's most perplexing and tragic problems are commendable and are to be encouraged.

### PIONEERING TO DO

But still there remains a large area to be explored and pioneered before society can feel that the basic problem has been satisfactorily solved. If State medicine or some form of compulsory insurance on a State or national basis under a vast bureaucracy is to be avoided, then adequate voluntary programs will have to be developed to meet the needs. Sooner or later that simple, obvious fact will have to be faced by both the medical profession and the people.

The State legislature has before it a bill that goes far beyond the principle of covering "catastrophe" cases. It calls for compulsory pay-roll taxes of 1 percent on both the employee and the employer. Under existing hospital bed shortages, the State under this plan would be in effect collecting taxes under misrepresentation because sufficient hospital facilities are not now, and will not for some time to come, be available for all potential cases under the proposed coverage. All of which does not mean that serious consideration at this time might not be given to the "catastrophe" problem.

Consideration might be given to the practicality of some form of deductible insurance. Here two points are suggested. First, the desirability of limiting such insurance so far as any State program is concerned to persons needing it most—those in the lower-income brackets. Second, keeping the premium so low that those eligible could not afford to be without the protection. Such a plan might be limited to single persons earning less than, say $2,500 a year, and to married couples with incomes under $5,000.

To keep the premium as low as possible and still to have a practical plan, the insurance would not begin to apply until medical care and hospital bills in any one year exceeded a specified amount. That might be $200 for single persons; $250 for married couples. There might be a slightly rising scale of premiums for married couples with dependent children under 18, but the total amount should be kept low.

Eligibility might be restricted to persons 18 to 40 or 45 years old who have been employed not less than 1 year in employment subject to unemployment insurance. Employers would be authorized to deduct sickness insurance premiums from pay rolls on voluntary application of eligible employees.

### SCHEDULES OF FEES

Persons not under covered employment but otherwise eligible after satisfactory showing of good health (similar to examinations for life insurance) could participate by mailing monthly premiums to the State fund.

Whenever medical care or hospital bills reached the specified amount for the insurance fund to operate proper notification would be made and further bills directed to the State fund for payment. To prevent any gouging, the fund management would prescribe a schedule of fees, and if claims exceeded such schedule they would be paid or rejected after a hearing or showing of cause.

The aim of such a program would be to remove the threat and fear of devastating medical bills from young people and families during the period when they are usually trying to buy a home, get established in business, and develop their earning power. As soon as such people improved their financial position and no longer were eligible to participate in the State plan, the various private plans would be available to them.

### DEVELOPING DATA

If sufficient data are not at hand to predicate such a plan on a sound insurance basis, the suggestion might be considered of a year's trial to develop such data. If the premium rates first tried were not sufficient to cover costs, they could be raised. The State could guarantee that all hospital fees under the program during this trial period would be paid so that hospitals already facing financial problems would not be asked to hold the sack.

The members of the medical profession might cooperate to the extent of being willing to go along for the trial period and to take their chances on pro rata payments out of funds in excess of the hospital bills covered by the insurance payments.

As it is, the doctors now take chances on getting their fees; if the proposed plan could be brought to practical application it would seem that in the future the doctors would not have to write off as many bad debts in the form of unpaid fees as they do now. Also this might be the practical answer to stemming the demand for a broader bureaucratic plan of State medicine.

[From the Chronicle, San Francisco, Calif., March 5, 1947]

## THE CURRENT HEALTH BILL

William T. Sweigert, executive secretary to Governor Warren and author of a health bill now before the legislature, rightly points out that illness sometimes creates an insupportable financial burden.

The cost of all medical care has risen through the years. The rise is in large part due to a good thing in itself—the advance in medical equipment and techniques. Fifty years ago most of this technical advancement had not happened, and a lot more patients died. It is here today, and it greatly enhances the chance of survival and recovery, but it necessarily costs money and in some cases can cost a ruinous amount.

No individual will do without the best medical care for a member of his family if he can possibly find the money. In too many cases of serious illness striking the family of modest means, the care is obtained at the cost of mortgaging the family's future for 10 or 15 years, sometimes even longer.

A single instance will suffice: Every year thousands of families in California are faced with some serious disease requiring surgical intervention. Surgery, laboratory fees, and X-ray costs may well run upward of $1,000. If recovery is protracted, hospital and nursing costs may run upward of another $1,000. This kind of blow can wreck the family of low or moderate income, and this hazard should be lifted.

It is misleading, however, for Mr. Sweigert to discuss his bill as if it were chiefly aimed at averting such catastrophes as mentioned above. What Mr. Sweigert's bill actually would do is provide insured hospitalization and treatment for a large part of human illness, serious or otherwise. Under its terms a person of ample means, ill with influenza, an uncomfortable but not usually a dangerous affliction, could demand hospital treatment simply because he or she would be more comfortable in a hospital than at home. This illustration deals not with a rare occurrence but with seasonal illness involving thousands, and it has its bearing upon the realities, as will be shown later.

The bill goes even further in this undesirable direction; it even covers pregnancy. And it does not go far enough in the other direction; it specifically excludes tuberculosis, except by option of the authority it creates, and tuberculosis can be very expensive. It has other undesirable features—such as the provision to send State-appointed physicians away for refresher courses at State expense—but its main drawback lies in its overambitious scope.

The following factors argue against so sweeping a bill:

1. Most probably a majority of the public does not want such a medical bureaucracy, or need it. Where lesser illnesses are concerned, two courses are already open to the individual—he may go to his physician or hospital in the ordinary way or, if he wishes to insure against the expense, he may join any of several prepay plans, all offering one degree or another of protection. Even the most successful of the prepay plans, however, such as Permanente Foundation, are unable to cover tuberculosis and certain forms of meningitis, for instance, which entail the very financial disaster to which Mr. Sweigert refers. In short, there already exist means to assure treatment of lesser illnesses, but present facilities do not offer all the disaster protection which is needed most. Mr. Sweigert's bill jeopardizes this more important protection by its emphasis upon lesser hazards, as will be shown.

2. There is a dire shortage of hospital accommodations and nursing personnel throughout the State, which cannot be remedied for several years at the earliest. A compulsory insurance plan which would finance the cost of hospitalizing virtually all illness would create a far larger number of patients, paid for in advance, than there is room for. In such a situation, beds would inevitably be assigned in order of gravity, and victims of lesser illness would be turned away even though they had paid for hospital care.

On this point, proponents of the bill argue that if the need for more hospitals is created more hospitals will be built. But there is more to building large plants just now than money, and in any case the State should not tax citizens to pay for a service until the State is prepared to deliver the service. It is the kind of nonperformance which could cause the plan to collapse.

The circumstances, therefore, argue against the bill as drawn. There might well be merit, however, in amending the bill, if possible, so that its benefits would be extended only to families visited with illness entailing extraordinary expense.

In view of the correlation between expense and seriousness, such a scheme would square with the realities as to hospital space and nursing personnel. It would protect against catastrophe without creating a bureaucracy to deal with every tonsillectomy. By no means incidentally, the premiums should be smaller since the insurance would cover a rarer incidence of illness.

The Chronicle 2 years ago supported Governor Warren in principle on health insurance. Since then it has come to the conclusion that the most realistic approach to the economic problem of community health is contained in a limited measure insuring against costly illness, but letting the little routine ills go.

Such a measure would get at the heart of the problem. It would sustain the economic position of those in lower income brackets attacked by costly illness. It would be comparatively small, manageable, and workable. The current bill is not workable in its present form, and the Chronicle recommends its rejection.

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[From PM, New York City, April 24, 1947]

## COMPULSORY HEALTH INSURANCE PLAN PUSHED BY GOVERNOR WARREN ON COAST

(By Albert Deutsch)

LOS ANGELES.—If, as they say out here, Gov. Earl Warren of California has one cool and calculating eye trained on the White House in every move he makes, then it is significant that this dark-horse Republican is putting his chips on a mildly liberal electorate in 1948, while the favorites in the Presidential race are staking their all on a conservative swing.

Take, for instance, Governor Warren's espousal of a compulsory health insurance bill introduced in both houses of the California Legislature. To many of his party colleagues, "compulsory" has been a bogey-word that sets off panicky oratory about conspiracies to convert the American way into totalitarianism. Governor Warren, it appears, does not share this phobia.

### GOVERNOR'S MILD BILL STILL TOO RADICAL FOR MEDICAL SOCIETY

The health insurance bill now sponsored by Warren is considerably milder than the one to which he gave half-hearted backing last year. But the reactionary California State Medical Society finds even this drastically watered-down version too radical to indorse.

Its well-heeled lobbyists in Sacramento—paid by heavy compulsory assessments from the society-regimented physicians of this State—are energetically trying to cripple or kill the bill.

The Warren-backed bill would provide hospital-care insurance for all employed workers now covered by State unemployment insurance, together with their dependents. The insured person would be entitled to hospital care up to 100 days per illness, medical and surgical services while a hospital patient, together with needed drugs, laboratory, X-ray, and other hospital services. The system would be financed by a compulsory pay-roll tax of 2 percent on wages up to $3,000 a year, half to be paid by the worker, half by the employer.

### WARREN'S BILL CONTRASTED WITH DEWEY DO-NOTHINGISM

The California bill falls far short of the Wagner-Murray-Dingell bill for Federal health insurance, which would give virtually complete insurance against all medical bills, whether incurred in hospital, doctor's office, or in the home, to be paid for by a compulsory pay-roll tax of 3 percent, shared equally by worker and employer. It is estimated that nearly 3,000,000 Californians would be eligible for the limited State health insurance if the Warren-backed bill passes. The State CIO is seriously considering support of the bill, with certain amendments, on the theory that it's better than nothing and the best buy under the circumstances.

Although the Warren-backed bill is gravely defective in several particulars, it represents a shining example of positive action as compared with the negativism of Gov. Thomas Dewey, of New York, who, after spending $100,000 in State money on a commission to study medical care, last year scrapped the report of the group he appointed when it suggested the possibility of a State-wide system.

The California bill was introduced after a State senate committee recommended last January that "there be established at once by the State a prepaid health-insurance system to protect people against the expenses of catastrophic illnesses." The legislative group, in espousing a compulsory health-insurance plan, noted that the California Physicians' Service, largest voluntary plan in the State, which was set up by organized medicine, in 9 years has been able to cover only 300,000 of that State's 9,300,000 residents.

### GRAVE DEFECTS IN CALIFORNIA BILL

The Warren-backed bill has five grave defects:

1. It is not really "health insurance," since it provides no means for preventing ill health (such as periodic examinations, early diagnosis and treatment). An individual has to wait until he is sick enough to need hospital treatment before he gets attention.

2. The bill opens the way to overexpensive accounting, confusion, and possible skullduggery by permitting employers to cover their workers through voluntary insurance plans entirely outside the State system. This gimmick would permit voluntary plans to concentrate on enrolling healthy groups of workers, while the State would be loaded with the worst health risks.

### MEASURE WOULD AID PRIVATE-PROFIT FIRMS

3. A section in the present bill also permits profit-making private insurance companies to underwrite groups who would then be exempted from paying into the State health-insurance fund. The idea of forcing workers to pay taxes for the benefit of profit-making private firms is objectionable from both the legal and ethical viewpoint.

4. Certain provisions of the bill would threaten ruin to existing group-practice prepayment plans that have been successful in California, notably the Ross-Loos Clinic in Los Angeles and the Kaiser-sponsored permanent health plan in the San Francisco Bay area.

5. A 2-percent pay-roll tax for the very limited benefits provided in the Warren measure seems excessive when compared with the Wagner-Murray-Dingell bill, which would cover nearly all medical bills with a 3-percent pay-roll tax.

It strikes me that Governor Warren, a conservative Republican, merits commendation for having gone as far as he has along the road to real health insurance. But I don't think he has gone far enough. Unless it is drastically amended to take out its present gimmicks, I don't believe the bill deserves the support of progressives.

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[From the Chronicle, San Francisco, Calif., August 28, 1946]

## COURT RULES ON PHYSICIANS' SERVICE PLAN

The California Physicians' Service, voluntary plan to provide prepaid medical and surgical care and hospitalization for low-income groups, is not an insurance plan within the meaning of California laws.

The State insurance commissioner, therefore, has no jurisdiction over the service, and no right to regulate it.

Without a dissenting vote, the California State Supreme Court so ruled yesterday in a decision expected to end years of litigation.

Shortly after the service was organized by the California Medical Association in 1939, Anthony Caminetti, Jr., then insurance commissioner, filed an action to determine whether his office had jurisdiction. He and his successor, Maynard Garrison, carried the suit to the State's highest tribunal.

The commissioner charged the service was a corporation illegally engaged in the practice of medicine and in the insurance business. The supreme court rejected that conception.

Approximately 5,000 physicians, all members of the California Medical Association, participate in the service, which has about 100,000 members. Membership is restricted to those earning less than $3,000 a year.

[From the Christian Science Monitor, Boston, Mass., May 19, 1947]

### CALIFORNIA SHELVES BILL FOR SICKNESS: INSURANCE

(By a staff correspondent of the Christian Science Monitor)

SACRAMENTO.—Gov. Earl Warren's proposal for a State sickness-insurance program for California has been shelved by the legislature.

The clinching action came when the senate governmental efficiency committee tabled the measure which would have levied a 1-percent tax on employers and a similar tax on employees to finance payment of doctor and hospital bills for persons in need of medical care.

The Governor had drafted his sickness-insurance bill in somewhat more restricted form than a similar measure which was defeated 2 years ago. As rewritten, it would have provided hospital and medical services for all California workers when they were judged indisposed enough to go to a hospital.

The 2-percent contribution was intended to produce a $127,700,000 fund. A stiff argument developed between economists and medical authorities as to whether this would be adequate to carry out the proposed program.

#### SUPPORT FOR VOLUNTARY PLAN

Defeat of the State sickness-insurance measure came in spite of a special senate committee endorsement of a limited program "to protect the people of this State against the peril of catastrophic illness." A special assembly committee reported in favor of adequate medical service on a voluntary basis but against State-wide compulsory health insurance. Both committees were appointed last year.

The senate committee's recommendations carried little weight with the new senate elected last November, which agreed generally with the minority committee reported by Senator Arthur H. Breed, Jr., of Oakland, that "the American people have had enough of panaceas."

Spokesman for the Alameda County Medical Association, Senator Breed pointed out that the association has advertised daily guaranteeing medical care to anyone in Alameda County, regardless of ability to pay, and had received no replies from persons in need of medical care because they could not pay.

#### ADEQUATE CARE AVAILABLE

"I am fully convinced," Senator Breed declared, "that the studies made by the committee's research staff, shorn of their propaganda and expressions of personal opinions, demonstrate that, outside of a shortage of hospital facilities, due directly to population growths in the past decade, and a shortage of trained medical personnel, due to the war, the State of California is in a comparatively good condition with respect to the availability of the separate services which comprise needed health care, but rather has been lumped together under the general head of 'medical care.' The economics of each service differs from the other, and to be treated intelligently and effectively each must be given different treatment. Compulsory health insurance is offered as a panacea. The American people have had enough of governmental panaceas."

#### HUGE COST FORESEEN

One of the most effective arguments against the Warren sickness-insurance proposal was that it would end in bankruptcy. Approximately $6,000,000 a year is already being spent by the California State Department of Public Health. In addition to health education and compilation of statistics, there are State divisions and bureaus for preventive medical services, maternity and infant care, crippled children services, three bureaus for communicable-disease control, public-health nurses, food and drug inspection, and a complete laboratory service.

Earle Grover, vice president of the Los Angeles Chamber of Commerce, testified in Sacramento that the financing proposed by the Governor would fall about $55,000,000 short a year; but Prof. Paul Dodd, of the University of California at Los Angeles, and Dr. Rodney Yoell, of the Medical College of Surgeons, said the estimated $128,700,000 to be produced annually by the 2-percent contributions would provide adequate financing and leave a potential $10,000,000 surplus.

Howard Burrell, of the Association of California Hospitals, called the bill a "strong step in social experiment to foist on the people of California."

[From the Examiner, San Francisco, Calif., May 7, 1947]

## Senate Group Kills Warren's Health and Equality Bills

Examiner Bureau, Sacramento, May 6.—The senate governmental efficiency committee today killed two major bills of the program of social legislation recommended to the legislature by Governor Warren.

They were Senator Byrl Salsman's measure to establish a State-wide plan of prepaid hospital and medical care, and Senator Jack B. Tenney's bill to establish a State commission on political and economic equality.

The committee which heard arguments for and against the measures at previous meetings, disposed of both bills summarily.

After tabling Tenney's bill Senator Ralph Swing commented:

"We have another bill floating around here. What do you want to do with it?"

Swing identified the measure as the "medicine" bill. A motion to table carried without a dissenting vote.

Today's action apparently presaged the second successive defeat for administration efforts to win adoption of a health-insurance program. Similar legislation, which would be financed by employee-employer contributions, was beaten at the 1945 session.

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[From the Bee, Sacramento, Calif., May 7, 1947]

## Off-Hand Like, the Senate Kills Health Insurance

In a free and easy manner, the senate committee on governmental efficiency has voted to kill Governor Warren's prepaid health-insurance bill.

The committee's deliberations on the vastly important measure at yesterday's session consisted of a casual question by Senator Ralph Swing, of San Bernardino County: "What do you want to do with the medicine bill?

Senator Thomas Keating, of Marin County, moved it be tabled. Senator Harry Parkman, of San Mateo County, seconded the motion. By a voice vote of the other members, the measure so far as the governmental efficiency committee is concerned, was killed and buried for the 1947 session.

This cavalier manner of dealing with what Senator Swing chooses to refer to as "the medicine bill" compares with the unceremonious even contemptuous treatment which a similar measure received at the hands of the assembly at the last session.

No matter what the views of the individual members may be on the subject of prepaid health insurance, the manner of disposing of the bill scarcely measures up to either the rules of order or the dignity generally ascribed to a house of the legislature.

The humble citizens of California, over whom hangs the ever-present threat of serious illness, hoped for a different action or at least an explanation of why the proposal should be tabled.

Of course, it is the same old familiar story.

Those who want health insurance and desperately need it are not represented in the halls of the State capitol by a persistent and well-heeled lobby.

To be sure they can continue to go to the loan sharks and put the best years of their lives in hock.

And for them, too, it is helpful that the assembly finance and insurance committee has refused the request of Corporation Commissioner Daugherty to limit charges on loans over $300 to a mere 10 percent.

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[From the Times, Los Angeles, Calif, May 7, 1947]

## Measure's Finish Seen by Backers

(By a Times staff representative)

Sacramento, May 6.—The senate governmental efficiency committee today tabled Governor Warren's bill providing for compulsory State health insurance.

The committee heard the bill about 2 weeks ago and took it under advisement. When the committee met today Senator Ralph Swing, chairman, asked, "What do you want to do with the medicine bill?"

### SPEEDY ACTION TAKEN

A motion to table was quickly given a second and in a flash the bill lay on the table "toes up." The chief author, Senator Byrl Salsman (Republican), Palo Alto, was not in the room at the time. Supporters of the measure indicated that today's action means the measure is dead, at least for this session.

A twin bill is in the assembly public health committee. It is due for a hearing shortly.

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[From the Bee, Sacramento, Calif., January 14, 1947]

## Here Are Reports of Senate Group on Health Plan

Public health insurance in a modified form was recommended, 3 to 2, today by the Salsman senate committee which has been studying the subject for the last 2 years.

To protect California from the "peril of catastrophic illness," said the committee majority (Salsman, Jespersen, Shelley) an immediate system of prepaid health insurance should be authorized by the present legislature but limited for the present to cases where the illness is long and the treatment costs great.

Senator Byrl Salsman, committee chairman, expressed the personal opinion this should apply to protracted illnesses affecting persons earning less than $3,000 a year.

### TWO ARE OPPOSED

The committee minority (Breed, Sutton) opposed this recommendation. Senator Arthur H. Breed, Jr., Alameda County, filed a minority report.

The whole committee endorsed State aid for the establishment of additional hospitals, taking advantage of Federal hospital aid. It was agreed there is a California shortage of hospital, laboratory, and diagnostic facilities at present.

There was one dissent (Breed) on the proposal for a health insurance commission to conduct a continuous study of medical care in California and to determine the need for an even broader public health insurance plan than that recommended now.

### URGES LICENSING

With Breed again dissenting, the committee urged the creation of a State insurance department division to license, regulate, and encourage voluntary health insurance systems.

Senator Breed in his minority report declared the people of California "do not want even this little dose of sovietization."

He termed the majority report an "un-American plan." "It is based," he said, "upon the wholly inadequate, hopelessly superficial, and unquestionably biased findings of a research staff that made its conclusions before it began its studies."

### BACKS VOLUNTARY PLANS

Breed's recommendations, in additon to concurring with the majority on the need for more hospitals, advocate:

1. Encouragement of voluntary health insurance plans.
2. Disapproval of any Government control plan on the ground the people have "had enough of regimentation."
3. An adequately financed joint legislative committee to continue studying the question.
4. An advisory committee to work with the legislative committeemen, members to come from all private and public groups which deal with services and facilities affecting the public health.

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[From the News, San Francisco, Calif., January 10, 1947]

## "Calamity" Bill for Health up—System Like Auto Insurance Proposed

Sacramento, January 10.—The first new proposal for health insurance from any member of this 1947 legislature was in the open today—a plan for "calamity insurance" to cover costs of severe illnesses, major operations, and long-term treatment.

Like deductible provisions of automobile insurance, this method would not apply to the early, relatively inexpensive sicknesses, which are being classified conversationally here as "the runny nose type."

Author of the idea—not yet a bill—is Ernest R. Geddes, chairman of the assembly interim committee which studied health insurance since 1945 and filed its report last July.

(The proposed measure is similar to legislation first suggested by the News columnist Arthur Caylor some months ago.)

Meanwhile, John F. Shelley, who has just stepped out of office as San Francisco's State senator, got most of the blame here today in capitol corridors for holding up action on the two-year senate report on compulsory health insurance.

Four of the five-member committee have been meeting here with Senator Byrl Salsman (R.), Palo Alto, chairman, seeking as much unanimity as possible in the half-dozen or less recommendations the committee expects to present. They plan another executive session Monday.

The major report is written and the recommendations are drafted. (One or more minority reports expected.) But ex-Senator Shelley, a member of the committee, has not indicated his reaction to them, after having the papers in his possession more than 3 weeks, according to Senator Salsman. His efforts to reach Mr. Shelley and press for quick action have been fruitless, he said.

### AWAIT HIS ACTION

His absence apparently leaves the committee split 2–2 on the compulsory angle.

The committeemen are inclined to excuse Mr. Shelley, who has just finished an intense political campaign and has returned to his post as San Francisco labor council president in the midst of severe labor-contract problems.

But they cannot deny they anxiously await his action on the health insurance report, one of the momentous announcements due this session.

Gov. Earl Warren, who as yet has no health insurance bill drafted and no plan beyond his inaugural hope for a compulsory State program, has said he will not prepare a bill until he has read this report.

Mr. Geddes told about his proposal at a meeting of the Sacramento Business and Professional Women's Club, in which he said the fundamental problem raised by Gov. Earl Warren's recommendations on the subject boils down to this:

"With how restricted a service will the people be satisfied?"

Mr. Geddes said he also intends to introduce a bill amending the now disability insurance program to admit women to benefits during 10 weeks of pregnancy. It would run 4 weeks before childbirth, 6 weeks after.

In a press statement issued after his Sacramento speech, Mr. Geddes was quoted as saying that a solution to the most pressing health pay problem lies in "a basic insurance to take care of those operations and treatments which cost the most but which can be the most cheaply insured against."

Since it was the assembly last session that spiked Governor Warren's health bills, the governor's legislative friends this time plan to steer initial moves from the senate side of the capitol. Hence special concern over the senate report, which was a better financed and more thorough job than Mr. Geddes' group was able to do.

In San Francisco Mr. Shelley told the News he had a copy of the report, but said he had not had it long enough completely to study the committee's proposals.

"You can't just blandly give a quick answer on such an important matter," Mr. Shelley said. "Since I was unable to attend any of the committee's sessions I want to study the report very closely. I can't just give Senator Salsman a flat agreement without careful study."

Mr. Shelley indicated he did not agree completely with some of the committee's ideas and said he would give his reactions to the report as soon as he had completed his study.

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[From the Chronicle, San Francisco, Calif., March 17, 1947]

## SICKNESS IN CALIFORNIA: WHY—WHEN

By J. Campbell Bruce

If there are five in your family, two of you will get sick or hurt in 1947.

Every morning some 300 Californians are undergoing appendectomies.

More babies are born in December than any other month.

If you're a fellow who plays the averages, you'd better lay 70 bucks aside right now. You'll need it for this year's sick bill.

These and other statistical facts on the incidence of sickness in California were gathered by the California physicians' service in an 8-year actuarial study.

### CASE HISTORIES

It was the first time such a study of the incidence of illness among a large group of people has been made.

Case histories of about 1,000,000 persons were used during those years to chart this statistical story of the hundreds of ailments listed in the United States Public Health Service mortality code.

For years a mortality code has listed internationally the causes of death. This has proved of great value to insurance companies.

But there has never been available, until this CPS coding, a comprehensive graph of sickness—a morbidity code as contrasted to a mortality code. (A code, in this regard, is simply a numerical listing or table of every malady known to mankind. It is a sort of thesaurus—each disease is given a number, such as heart disease, and under that number are listed all the related ailments of the heart.)

Social Security and other governmental agencies, as well as employers, have shown an interest in the study. It was conducted under the direction of Dr. A. E. Larsen, medical director of the service.

### HEAVY TURNOVER

Although the service now has 450,000 members throughout the State, the survey is actually based on about 1,000,000, for during the war years there was a heavy turn-over.

The study revealed that on a year's average 32 persons out of every 1,000 are either injured or have an illness which requires some sort of medical attention.

Most healthful months appear to be those of spring—April, May, and June. You're most likely to come down with something, get kicked in the shins or undergo surgery in August, September, January, February, and March.

Ulcers pop out most frequently during those winter months because, Dr. Larsen says, people eat richer foods and drink more on dull and cold wintry days.

### THOSE COLDS

Incidence of tuberculosis is higher then, too. More people come down with colds. A cold may run into a fever, the fever may light up a spot or latent infection in the lung and a TB treatment is called for.

High-blood pressure and heart attacks occur most frequently in March and October—in March, because of the contributory factors of other diseases; in October, because deer hunters and vacationers over-exert themselves.

Allergic rhinitis (hay fever) occurs most in July and August, the months of pollen. Those same months are the favorites for getting those tonsils out, and for good reason—kids won't be missing any school.

April is the balmiest month when it comes to health—the average is 27.77 sick persons out of 1,000. But beware of the Ides of March, the sickest month of them all—the average has jumped to 39.4.

Injuries befall most people in August, September, December, January, February, and March. Vacations in August and September account for a high percentage whereas the rise in those other months is due to wintry conditions.

### SURGERY

The graph on surgery also always rises in August and September, apparently the two favorite vacation months of the year.

These are the months of the elective operations. If they've got a choice and can postpone an operation, they take it during these two months. Another reason is that hospital beds in winter are usually filled with patients suffering cold-induced ailments.

Incidence of sickness is also reflected in social and economic changes, Dr. Larsen found.

"During the war years," he declared, "people were under a stress and the obligation of wartime production. As a consequence, they put medical care off.

If they had varicose veins, they didn't bother—they didn't want to take time off for treatment."

There was a downward trend in some ailments. But 1946 was a heavy medical year. People had money and time. They finally got around to having the doc look at that leg or check up on that pain in the back. Like everything else, however, he expects a slacking off will begin this year.

### NOSTRUMS

Statistics garnered in this study, Dr. Larsen said, bear out the reason why quacks put on their biggest selling campaigns in the spring, usually April. While the nostrums do no good—and in many instances no particular harm—the victim feels these "medicines" have made a new man out of him. He eats better, sleeps better, is full of bounce.

Know why? The answer is quite simple.

"In the long, dark winter months," Dr. Larsen explains, "the average man doesn't get enough sunshine, fresh air and, exercise His food isn't right and he may drink a little too much. His resistance is low and he comes down with a respiratory sickness. The cold and the rains make his bones ache. The accumulation of depletion of winter reaches its peak in March.

"All right. And now comes April and more stable weather. He gets outdoors more, breathes deeper, gets sunshine. He eats fresh vegetables. The very air is tonic. The blossoming of trees has a salutary effect on him—just the sight of it. He is a new man. And he doesn't have to take pills to feel that way. In spring, as the poet said, a young man's fancy turns to love. So does all nature."

And that, Dr. Larsen conjectured, is why more babies are born in December.

Senator SMITH. The next witnesses we have are Dr. Thomas A. McGoldrick and Dr. Floyd S. Winslow, of the Medical Society of New York.

## STATEMENT OF DR. FLOYD S. WINSLOW, MEDICAL SOCIETY OF NEW YORK, ACCOMPANIED BY DR. THOMAS A. McGOLDRICK, MEDICAL SOCIETY OF NEW YORK

Dr. WINSLOW. I represent the Medical Society of the State of New York. I am a past president of the society and a member of the council of the State society and a delegate for 20 years from the Medical Society of the State of New York and the American Medical Association. Dr. McGoldrick and I had been appointed by the council of the Medical Society of the State of New York to appear here for them.

Senator SMITH. All right, Doctor.

Dr. McGOLDRICK. Dr. Winslow thought I might talk here.

Dr. WINSLOW. I think his is a little more important than my part.

Senator SMITH. All right, Dr. McGoldrick.

Dr. McGOLDRICK. I am past president of the New York State Medical Society and for many years one of their delegates in the American Medical Association and a member of the council of medical care in the American Medical Association.

The Medical Society of the State of New York has studied S. 545 carefully. We wished to determine whether or not it would solve some of the problems of medical care and how far it would go in rendering effective the 10-point program of the American Medical Association, which has been approved by the New York society.

It would appear that the greatest needs for improvement in our present medical-care system come under four headings.

Public-health facilities, including preventive medicine.

Maternity and prenatal care and child care.

Diagnostic centers and hospitals with proper distribution of physicians.

Facilitating the prepayment of hospital- and medical-care bills through voluntary insurance, with protection of the principle of free choice of physician. The prepayment principle is especially important for those of low or moderate income.

Under the first heading, it should be borne in mind that only in slightly more than half of the 3.070 counties in the United States is there a full-time public health service. It is not necessary or feasible for every county to have a full-time health department. Several rural counties, however, could combine in the employment of a health staff and the maintenance of a central office, with a traveling health service and laboratory. The protection of food, water, and milk supplies, sewage disposal, and mosquito and fly control eliminates or diminishes the incidence of certain diseases. This lessens the need for medical care.

S. 545 in title I, section 102 (c) (2), provides that the National Health Agency shall have responsibility for Federal governmental activities concerned with the prevention of disease through water purification, sewage treatment, and the elimination of lake and stream pollution, and promotion of research toward this end.

It would seem that this section could be amplified to advantage and a provision made for financial assistance to and encouragement of the formation of county or district health departments, wherever financial need can be shown.

It cannot be too strongly emphasized that the prevention of disease through public health measures renders much medical care unnecessary.

With reference to the second heading, S. 545 makes general provisions for maternal, prenatal, and child health in title I, section 102 (c) (3). In section 103 (b) it provides for the transfer of the functions and duties of the Children's Bureau to the National Health Agency. However, in section 104, it does not state the qualifications of the head of the Office of Maternal and Child Health.

The present law provides that the duties of the Children's Bureau are—

> to investigate and report upon all matters pertaining to the welfare of children and child life among all classes of people and especially to investigate the questions of infant mortality, birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, and legislation affecting children in the several States and Territories.

The functions of this division should be held strictly to the foregoing responsibilities. The present Children's Bureau in the past has exceeded these functions by setting standards and methods which attempted to govern practice. Any matters of medical care will be provided under the Office of Medical and Hospital Care Services. Since the results of the studies assigned to the Office of Maternal and Child Health will determine the amount of medical care necessary for this group among those unable to provide such care for themselves, it is believed that thought should be given to making this office a subdivision of the Office of Medical and Hospital Care.

Section 104 (d) provides for an Advisory Council on Maternal and Child Care. According to the bill, only three of the eight members of this council need be doctors of medicine. It also provides that these three must be specialists in obstetrics or pediatrics. It is recommended that the bill provide that at least half of the council shall be doctors of medicine, at least one of whom shall be an obstetrician, at least one a pediatrician, at least one a general practitioner, and the fourth drawn from any of these three fields of medicine just enumerated. Since some of the duties prescribed have a legal aspect, it would also seem advisable that a lawyer should be on the council.

Senator SMITH. Doctor, I hesitate to rush you, but the bell has rung and some of us have duties on the floor. I wonder if we couldn't file your statement, if this is the statement you are referring to, in the record, which is what we want.

Dr. McGOLDRICK. All right, Senator.

Senator SMITH. Would that be satisfactory?

Dr. McGOLDRICK. Yes.

Senator SMITH. We have to conclude these hearings on account of our Senate sessions. Thank you very much and I apologize.

(The brief submitted by Dr. McGoldrick is as follows:)

MAY 29, 1947.

### AMENDMENTS AND SUGGESTIONS OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK ON S. 545 (TAFT-SMITH-BALL-DONNELL BILL)

The medical society of the State of New York has studied S. 545 carefully. We wished to determine whether or not it would solve some of the problems of medical care and how far it would go in rendering effective the 10 point program of the American Medical Association, which has been approved by the New York society.

It would appear that the greatest needs for improvement in our present medical care system come under four headings.

1. Public health facilities, including preventive medicine.
2. Materinity and prenatal care and child care.
3. Diagnositc centers and hospitals with proper distribution of physicians.
4. Facilitating the prepayment of hospital and medical care bills through voluntary insurance, with protection of the principle of free choice of physician. The prepayment principle is especially important for those of low or moderate income.

Under the first heading, it should be borne in mind that only in slightly more than half of the 3,070 counties in the United States is there a full-time public health service. It is not necessary or feasible for every county to have a full-time health department. Several rural counties, however, could combine in the employment of a health staff and the maintenance of a central office, with a traveling health service and laboratory. The protection of food, water, and milk supplies, sewage disposal, and mosquito and fly control eliminates or diminishes the incidence of certain diseases. This lessens the need for medical care.

S. 545 in title I, section 102 (c) (2), provides that the National Health Agency shall have responsibility for Federal governmental activities concerned with "the prevention of disease through water purification sewage treatment, and the elimination of lake and stream pollution, and promotion of research toward this end."

It would seem that this section could be amplified to advantage and a provision made for financial assistance to and encouragement of the formation of county or district health departments, wherever financial need can be shown.

I cannot be too strongle emphasized that the prevention of disease through public health measures renders much medical care unnecessary.

With reference to the second heading, S. 545 makes general provisions for maternal, prenatal, and child health in title I, section 102 (c) (3). In section 103 (b) it provides for the transfer of the "functions and duties of the Children's Bureau" to the National Health Agency. However, in section 104, it does not state the qualifications of the head of the Office of Maternal and Child Health. The present law provides that the duties of the Children's Bureau are, "to investigate and report upon all matters pertaining to the welfare of children and child life among all classes of people and especially to investigate the questions of infant mortality, birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents, and diseases of children, employment, and legislation affecting children in the several States and Territories." The functions of this division should be held strictly to the foregoing responsibilities. The present Children's Bureau in the past has exceeded these functions by setting standards and methods which attempted to govern practice. Any matters of medical care will be provided under the Office of Medical and Hospital Care Services. Since the results of the studies assigned to the Office of Maternal and Child Health will determine the amount of medical care necessary for this group among those unable to provide such care for themselves, it is believed that thought should be given to making this office a subdivision of the Office of Medical and Hospital Care.

Section 104 (d) provides for an advisory council on maternal and child care. According to the bill, only three of the eight members of this council need be doctors of medicine. It also provides that these three must be specialists in obstetrics or pediatrics. Thus it would be possible to have all three from one specialty. It is recommended that the bill provide that at least half of the council shall be doctors of medicine, at least one of whom shall be an obstetrician, at least one a pediatrician, at least one a general practitioner, and the fourth drawn from any of these three fields of medicine just enumerated. Since some of the duties prescribed have a legal aspect, it would also seem advisable that a lawyer should be on the council.

With reference to heading (3), the National Hospital Survey and Construction Act of 1946 has opened the way for a solution of this problem. While the extention of hospital and diagnostic centers will undoubtedly attract physicians to many areas which now have none, nevertheless, in some areas further inducements must be offered. S. 545 in title VII, part B, section 712 (a) (4) provides that incentive by specifying that the program "may also include payments to physicians practicing in areas which, without such payments, would be unable to provide sufficient income to attract a practicing physician." This provision in conjunction with the provisions of the Hospital Survey and Construction Act should go a long way towards making a better distribution of physicians.

Heading (4) is assisted by S. 545 by title VII. Whereas the indigent are taken care of very well in many sections of the country, especially in cities and large towns, there are areas where they receive inadequate care and the provisions of S. 545 will provide for this group. The economic group which can pay part but not all of its medical care bills will be particularly benefited by this section. The provision whereby payments in whole or in part may be made to any nonprofit voluntary health, hospital, or medical insurance fund is a particularly helpful one. This will stimulate further development and expansion of these voluntary plans.

There is a segment of the population which can pay for its medical care without difficulty. This group needs no assistance and should not be compelled to take part in any plan.

Also there is the group which can take care of all minor illness, but which finds difficulty in meeting prolonged or expensive illness, such as those involving hospitalization, surgery, or obstetrics. The voluntary insurance plans available cover these eventualities. While they do not yet afford coverage of a large enough segment of the population, they are growing rapidly and have had a tremendous increase in number of subscribers during the last year. For example, the six voluntary medical care plans in New York State, as of December 31, 1946, had an enrollment membership of 598,042, which was an increase of 329,794 during the year, or 122 percent.

During the first 4 months of 1947 there has been an increase in membership of 170,000, and at the present rate of growth, it is reasonable to assume that the plans will double their 1946 enrollment by the end of this year.

Nationally these plans now have an enrollment of approximately 5,000,000, which is double the enrollment of a year ago. More than 90 plans are now in operation in 37 States and the District of Columbia. The other States have plans in the process of organization. The national membership of Blue Cross hospital plans has reached a figure of 25,876,424 and has increased in the last 12 years at an average number of 2,148,285 members per year, giving some indication of the likely coverage of voluntary hospital insurance. Since, during the first 7 years of voluntary plans the rate of growth paralleled the first 7 years' growth of hospital plans, it is reasonable to assume that the coverage of voluntary medical care plans will eventually equal the coverage by hospital plans.

Besides these voluntary plans other coverage on a voluntary basis is provided through commercial companies. Approximately 7,800,000 persons are covered under commercial surgical plans, and an additional 1,500,000 under a more comprehensive program including medical care on a group basis. There are also approximately 1,500,000 individuals insured for surgical benefits on an individual basis. Similarly, there are approximately 7,000,000 people covered under health and accident insurance, which provides a weekly income in cases of sickness or accident on a group basis, and approximately 8,000,000 are insured under health and accident contracts on an individual basis. These figures show another 25,000,000 individuals receiving various degrees of coverage.

Besides these commercial plans there are also approximately 25,000,000 individuals covered by industrial plans. Two years ago there were 1,500 corporations having some form of industrial medical coverage for their employees. The character of this coverage varies, in some instances specifying the individual, and in others the family as well. Many of these are partially supported by voluntary contributions from the employees.

The total of all of these voluntary methods show that at least 55,000,000 contracts in the United States have some kind of voluntary insurance against sickness and accident. A number of these are duplications. Yet, these figures do not include the more than 25,000,000 persons covered by hospital insurance, many of whom carry both types of insurance.

The voluntary plans in the United States have not yet fully shown what their maximum coverage may eventually be. It is believed that extension and modification and improvement of our present methods of providing health protection and medical and hospital care, together with a modified version of S. 545, will effect a major improvement in the medical care situation of the Nation.

The voluntary system involves no red tape, and the costs are less than those of the compulsory system. It provides free choice of physician and permits the subscriber to purchase his medical care when and where he wants it, within the limits of existing and growing plans. The American Medical Association has long suggested that the Government make use of the voluntary plans by paying the premiums for the medically indigent. This S. 545 provides.

For more than 70 years the American Medical Association has asked that all Federal agencies concerned with health be placed in a single department of which the secretary should be a doctor of medicine. S. 545 does provide for the grouping of these activities into a single agency. Although the agency is not an executive department, it has almost equal status and it is provided that the administrator shall be a doctor of medicine who has been a practicing physician.

Title VII, part B, section 712 (a) (1) provides that by 1949 the State agency administering the plan must be the State health agency. Elsewhere there has been a distinct separation of public-health functions from medical-care functions. Hence, while for facility in administration, a single State agency may be required as the sole administrative agency, there seems no logical reason why this must be the State health agency. Some States might prefer to have an independent medical agency handle the problem and should be permitted to do so.

There is no provision anywhere in the bill as to who shall be the acting administrator in case of illness or a vacancy. Since the administrator must be a doctor of medicine, it seems logical that the director of medical and hospital care services should be the acting administrator.

While the functions of the agency are specified, nowhere do the functions and duties of the administrator appear, except as to authority of appointment, making of expenditures, and necessity of making annual reports. His authority over the eight constituent units established in section 104 (a) should be defined.

We agree with the decentralization provided for in the bill. No Federal agency can or should control local problems, except as to standards to be met. States are able to determine their own needs, the needs of their citizens and the best ways of meeting those needs.

We approve the general philosophy of the bill as being sound and democratic. We feel that it meets several of the points necessary for better health in the United States as propounded by the American Medical Association.

These amendments and suggestions would, in our opinion, clarify the bill and make it more effective, and we urge their adoption.

The Medical Society of the State of New York, comprising more than 21,000 members, stands ready at any time to assist in furthering better health for the State of New York and the Nation. It believes that this can be done best by a voluntary, decentralized system as generally proposed in S. 545, and by improving and expanding our present system based on private enterprise.

*Medical-care plans throughout the United States*

| Name and location | Approved by a medical society | | Type of contract | | Types of benefits | | | | Monthly rates | | | | Membership Dec. 31, 1946 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Individual | | | | |
| | Yes | No | Service | Indemnity | Surgical | Medical and surgical, in hospital | Medical and surgical, home, office, hospital | Maternity | Male | Female | 2 persons | Family | |
| Hospital Service Corp., Birmingham, Ala | ---- | X | ---- | X | X | X | ---- | X | $0.75 | ---- | $1.50 | $2.00 | 45,928 |
| Hospital Service of California, Oakland, Calif | ---- | X | ---- | X | X | X | ---- | ---- | [1]1.20<br>.40 | [1]$0.30<br>.60 | [1].50<br>1.00 | [1].80<br>1.60 | ---- |
| Intercoast Hospitalization Insurance Association, Sacramento, Calif | ---- | X | ---- | X | X | ---- | ---- | X | .35 | .45 | .80 | 1.35 | ---- |
| California Physicians' Service, San Francisco, Calif | X | ---- | X | ---- | X | ---- | X | X | [1]1.90<br>.80 | [1]1.90<br>1.20 | 2.00 | 3.00 | 439,000 |
| Colorado Medical Service, Denver, Colo | X | ---- | X | ---- | X | ---- | ---- | X | .75 | ---- | 1.50 | 2.00 | 170,000 |
| Group Hospital Service, Wilmington, Del | X | ---- | ---- | X | X | ---- | ---- | X | .60 | ---- | ---- | 1.65 | ---- |
| Florida Medical Service Corp., Jacksonville, Fla | X | ---- | X | ---- | X | ---- | ---- | X | .80 | ---- | ---- | 2.00 | 5,000 |
| Iowa Medical Service, Des Moines, Iowa | X | ---- | X | ---- | X | X | ---- | X | [1].25<br>1.00 | ----<br>---- | ----<br>---- | [1].75<br>2.50 | 17,000 |
| Kansas Physicians' Service, Topeka, Kans | X | ---- | X | ---- | X | X | ---- | X | .90 | ---- | ---- | 2.25 | ---- |
| Surgical Care, Inc., Kansas City, Mo | X | ---- | ---- | X | X | X | ---- | X | [1]1.10<br>.75 | ----<br>---- | [1]1.20<br>1.50 | [1]1.25<br>2.00 | 115,000 |
| Hospital Service Association, New Orleans, La | ---- | X | ---- | X | X | ---- | ---- | X | .75 | ---- | 1.50 | 2.00 | ---- |
| Massachusetts Medical Service, Boston, Mass | X | ---- | X | ---- | X | ---- | ---- | X | .85 | ---- | 1.65 | 2.00 | 461,000 |
| Michigan Medical Service, Detroit, Mich | X | ---- | X | ---- | X | ---- | ---- | X | .60 | .00 | 1.60 | 2.25 | 850,000 |
| Missouri Medical Service, St. Louis, Mo | X | ---- | ---- | X | X | ---- | ---- | X | .85 | ---- | 1.85 | 2.25 | 65,000 |
| Nebraska Medical Service, Omaha, Nebr | X | ---- | ---- | X | X | ---- | ---- | X | .75 | ---- | 1.50 | 2.00 | 22,000 |
| New Hampshire, Vermont Medical Service, Concord, N. H | X | ---- | ---- | X | X | ---- | ---- | X | .75 | ---- | 1.50 | 1.75 | ---- |
| Medical Surgical Plan of New Jersey, Newark, N. J | X | ---- | X | ---- | X | X | ---- | X | .75 | ---- | ---- | 2.00 | 100,000 |
| Northeastern New York Medical Service, Albany, N. Y | X | ---- | X | ---- | X | X | ---- | X | 1.00 | ---- | 1.75 | 2.25 | 5,000 |
| Western New York Medical Plan, Buffalo, N. Y | X | ---- | ---- | X | X | ---- | ---- | X | .60 | ---- | ---- | 1.70 | 104,000 |
| United Medical Service, New York City | X | ---- | ---- | X | X | ---- | ---- | X | .40 | ---- | 1.00 | 1.80 | 405,000 |
| Do | ---- | ---- | X | ---- | X | ---- | ---- | X | .52 | ---- | 1.12 | 2.00 | |
| Do | ---- | ---- | X | ---- | ---- | X | ---- | X | .64 | ---- | 1.36 | 2.36 | |
| Do | ---- | ---- | X | ---- | ---- | ---- | X | X | 1.60 | ---- | ---- | 4.00 | |
| Central New York Medical Plan, Syracuse, N. Y | X | ---- | ---- | X | X | ---- | ---- | X | .60 | ---- | ---- | 1.70 | 15,000 |
| Medical Surgical Care, Utica, N. Y | X | ---- | ---- | X | X | ---- | ---- | X | .75 | ---- | 1.50 | 1.90 | 50,000 |
| Do | ---- | ---- | ---- | X | ---- | ---- | X | X | [1].40 | ---- | [1].75 | [1]1.00 | |
| Genesee Valley Medical Care, Rochester, N. Y | X | ---- | ---- | X | X | ---- | ---- | X | .60 | ---- | ---- | 1.70 | 15,000 |
| Hospital Savings Association of North Carolina, Chapel Hill, N. C | X | ---- | ---- | X | X | ---- | ---- | X | .60 | ---- | ---- | .90 | 315,000 |
| Medical Service Association, Inc., Durham, N. C | X | ---- | ---- | X | X | ---- | ---- | X | .85 | ---- | ---- | 1.08 | 50,000 |
| North Dakota Physicians' Service, Fargo, N. Dak | X | ---- | X | ---- | X | ---- | ---- | X | .75 | ---- | 1.50 | 2.25 | 6,000 |
| Ohio Medical Indemnity, Columbus, Ohio | X | ---- | ---- | X | X | ---- | ---- | X | .60 | ---- | ---- | 1.90 | 75,000 |
| Oklahoma Physicians' Service, Tulsa, Okla | X | ---- | ---- | X | X | ---- | ---- | X | .75 | ---- | 1.50 | 2.00 | 23,000 |
| Oregon Physicians' Service, Salem, Oreg | X | ---- | X | ---- | X | ---- | X | X | 2.50 | ---- | ---- | ---- | 100,000 |

[1] Medical rider.

*Medical-care plans throughout the United States*

| Name and location | Approved by a medical society | | Type of contract | | Types of benefits | | | | Monthly rates | | | | Membership Dec. 31, 1946 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Individual | | | | |
| | Yes | No | Service | Indemnity | Surgical | Medical and surgical, in hospital | Medical and surgical, home, office, hospital | Maternity | Male | Female | 2 persons | Family | |
| Medical Service Association of Pennsylvania, Harrisburg, Pa. | X | | X | | X | | | X | $0.60 | | $1.25 | $2.00 | 85,000 |
| Do | | | | | | X | | X | 1.10 | | 2.20 | 3.25 | |
| Group Medical and Surgical Service, Dallas, Tex | X | | | X | X | X | | X | .75 | | | 2.00 | 20,000 |
| Vermont Physicians' Service, Rutland, Vt | X | | | X | X | | | X | .75 | | 1.50 | 1.75 | |
| Do | | | | | | X | | X | .65 | | 1.30 | 1.50 | |
| Virginia Medical Service Association, Richmond, Va. | X | | X | | X | X | | X | .85 | | 1.50 | 2.00 | 75,000 |
| Surgical Care, Inc., Roanoke, Va | X | | X | | X | | | X | .75 | | 1.50 | 1.75 | |
| Washington State Medical Bureau, Olympia, Wash | X | | X | | X | | X | X | 1.75 | | | 5.25 | 360,000 |
| Marion County Medical Service, Fairmont, W. Va. | X | | X | | X | X | | X | .85 | | 1.55 | 1.85 | |
| Medical-Surgical Care, Inc., Parkersburg, W. Va | X | | X | | X | X | | X | .85 | | 1.65 | 2.00 | |
| Wisconsin Plan, Madison, Wis | X | | X | | X | | | X | [2] 1.00 | | [2] 3.90 | [2] 5.00 | |
| Surgical Care, Milwaukee, Wis | X | | X | | X | X | | X | .90 | | | 2.50 | |
| Louisiana Physician's Service New Orleans, La | X | | X | | X | | | X | .85 | | 1.85 | 2.10 | |

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[2] Including hospitalization.

(Whereupon, at 12 noon, Thursday, June 5, 1947, the subcommittee adjourned to reconvene at 9:30 a. m. Friday, June 6, 1947.)

# NATIONAL HEALTH PROGRAM

FRIDAY, JUNE 6, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
*Washington, D. C.*

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Smith, Murray, and Ellender.

Senator Smith. The committee will please come to order. We have as our first witness Dr. Bradford Murphey, who is the chairman of the board of trustees of the Colorado State Medical Society of Denver, Colo.

Dr. Murphey, will you please state your background, before you begin, and your biography, so to speak, to indicate your qualifications as a witness?

## STATEMENT OF DR. BRADFORD MURPHEY, CHAIRMAN, BOARD OF TRUSTEES, COLORADO STATE MEDICAL SOCIETY, DENVER, COLO., AND MEMBER, BOARD OF DIRECTORS OF THE UNITED PUBLIC HEALTH LEAGUE

Dr. Murphey. For the record, my name is Bradford Murphey. I represent the United Public Health League of America. I am a member of its board of directors. I also represent the Colorado State Medical Society and I am chairman of its board of trustees. I am a graduate of the University of Nebraska, College of Medicine. My specialty is psychiatry and I am assistant professor of psychiatry at the University of Colorado.

The United Public Health League was organized in Salt Lake City, Utah, on January 29, 1944, at a meeting of the legislative chairmen and officials of the State medical associations in Arizona, California, Colorado, Idaho, Nevada, and Utah. It is a voluntary, nonprofit cooperative association. Its purposes, as set forth in its constitution and bylaws are as follows:

1. To educate the public to the proper evaluation of medicine, dentistry, nursing, and the allied health sciences;
2. To make social, economic, and other studies pertaining to the preservation of the public health and the care and treatment of the sick and injured;
3. To gain the enactment of Federal legislation effecting the greater usefulness of ethical medicine, dentistry, nursing, and allied health sciences;
4. To protect the public health, particularly by suggesting and supporting desirable forms of medical, dental, and public-health legislation submitted to the Congress of the United States;

5. To protect the public against quackery and patented nostrums, fraudulent advertising, and the medical practices of unqualified persons and groups;

6. To support those agencies having public-health duties and functions in their efforts to reduce the prevalence of disease and disability and to promote the health of the people; and

7. To protect qualified persons, institutions, and agencies engaged in the care and treatment of the sick, against unjust encroachment upon their functions and activities.

The United Public Health League is a simple federation of State medical associations. It is not a propaganda or publicity organization. It operates as a liaison agency between the medical associations within its membership and the various branches of the National Government. It acts nationally in the same manner that the legislative commitees of State medical, dental, and allied organizations work within their own States.

Membership in the league is by State medical associations rather than by individual physicians. The aggregate membership in the State medical associations which make up the United Public Health League as this time is approximately 12,250 physicians or slightly less than 10 percent of the total number of physicians in the Nation as a whole. (See appendix I.)

The Colorado State Medical Society was organized on October 31, 1888, to promote the science and art of medicine and the betterment of the public health. At the present time, the society has 1,250 active members or about 85 percent of the practicing doctors of medicine in the State. Its policies are determined, and its officers and board of trustees are elected, by a house of delegates which represents the county and district component societies in proportion to their membership. The House of Delegates meets at least once each year. When it is not in session, the society is governed by its executive officers and a board of trustees. (See appendix II.) Under these officers, the society conducts its business through 13 standing committees, 9 public-health committees, and 12 special committees.

The Colorado State Medical Society owns the Rocky Mountain Medical Journal, a monthly publication, and operates it on a nonprofit basis jointly for itself and for the State medical societies of New Mexico, Utah, and Wyoming, as the official journal for these four medical societies and also for the Rocky Mountain Medical Conference and the Colorado Hospital Association.

This testimony will deal with three principal topics: 1. Principles to be observed in the development of a sound national health program in a free, democratic society; 2. Acceptable features of Senate bill 545; and, 3. Criticism of certain provisions of the bill and some suggestions for its amendment.

The principles to be observed in the development of a sound national health program in a free, democratic society are as follows:

1. In a free society, most real wealth and all goods and services are primarily the product of individual initiative and personal effort. It follows, therefore, that a national health program, consistent with this way of life, must encourage the individual to provide health protection for himself and his family through his own effort.

2. A free, democratic society does not guarantee the right to free shelter, free clothing, free food, or free medical care. On the contrary, if a society is to stay free, it can only guarantee the right to be free to earn such goods and services.

3. A sound national health program in a truly democratic society, therefore, must recognize the social obligation of every individual citizen to provide through his own effort for his health protection insofar as his means, his social circumstances and his physical ability will permit.

4. In a free society, individuals or groups of individuals must be left free to provide for their own health protection by methods of their own selection, providing the methods selected do not restrict the rights of others through the use of force or compulsion.

5. While the individual has no inalienable right to free health protection, it must be recognized that society has a moral obligation to assist him in the protection of his health in all those public-health situations where the individual is powerless to act effectively alone and also where, as the result of poverty or personal disability, he cannot provide protection for himself.

6. While society has a moral obligation to assist the destitute and the disabled in matters of health protection, it has even greater obligation to do this in a way that will increase the individual's appreciation of his own obligations and by methods that will not make him increasingly irresponsible and dependent upon the State.

7. To be compatible with our American way of life, a national health program must strengthen existing free health institutions, agencies, methods and procedures, by stimulating voluntary cooperation on the part of individuals and groups. For exactly this same reason, it must also avoid all forms of compulsion since such compulsion inevitably fosters social regimentation, destroys individual initiative and thus impairs the quality of medical skill and service.

8. To fit our American concepts of democracy, a national health program must also preserve the freedom of personal relationship between patient and doctor—the patient's freedom to select his own doctor and the doctor's freedom to choose his own patients.

9. Since most of the illness of the wold today is psychosomatic in nature, at least to some degree, and since all psychotherapy depends upon a free and comfortable doctor-patient relationship, it follows that any form of compulsion in the doctor-patient relationship, or even any depersonalization of this relationship by assembly line methods, must inevitably bring about a rapid deterioration in treatment results.

10. In this connection, it must be recognized that, while health is important, it is not as important as freedom, either for the individual or for the group. Health for its own sake, without dignity and freedom, is not only a false value but actually an impossibility since the lack of freedom destroys the mental, emotional, and moral health of the individual and the group.

11. And finally, it is important to remember that a sound national health program cannot be built upon the false assumption that the end always justifies the means. No end, however important—not even life itself—can possibly justify the use of such means as are advocated by the proponents of compulsion. Voluntary methods may at times be exasperatingly slow, but at least they do not destroy human values such as freedom and personal responsibility, and they do develop the capacity for cooperation and thus strengthen human character.

Now as regards the acceptable features of Senate bill 545. In general, both the aims and the methods advocated in Senate bill 545 are in accord with the principles set forth above. We urge its passage because:

1. It provides for a voluntary, rather than a compulsory, national health program. Individuals and groups of all kinds are left free to accept it or reject it. It does not force those who can pay for services, and who desire to do so, into a bureaucratic Federal system.
2. Its provisions permit the full voluntary use of private agencies such as our medical service and hospital service plans whose rapid growth demonstrates both their undoubted success and their acceptability to our people. (See appendixes III and IV.)
3. The indigent and medically indigent are provided with a free choice of doctors, and the doctor is left free to choose his patients.
4. It provides the authority necessary to offer medical service and hospital service plans to several millions of Federal employees.
5. It will probably encourage students of the right caliber to enter the medical profession since it permits enough free competition to reward competency and enough personal freedom to make the medical profession attractive.
6. Hospital construction will undoubtedly be facilitated in rural areas by this bill. At the present time, many rural areas cannot afford the full cost of hospital construction. By carrying a part of this load, the bill will increase the availability of hospital resources to all of our people.
7. Its provisions will tend to restrict the activities of the United States Public Health Service strictly to the field of public health and not only keep it out of partisan politics, we hope, but also keep it out of the field of active medical practice.
8. In a similar manner, it will tend to concentrate the activities of the Children's Bureau in the area in which the Bureau was originally intended to operate.
9. It provides that the director of the Office of Medical and Hospital Care Services must be a doctor of medicine with at least 5 years of active medical practice and who is outstanding in the field of medicine. This provides at least some measure of protection against the arbitrary directives and immature judgments of the inexperienced and impractical type of idealist, occasionally found in some of our governmental health bureaus and agencies.
10. It very wisely provides that the actions and decisions of the director of the Office of Medical and Hospital Care Services shall be subject to review by the United States courts and, if necessary, by the Supreme Court of the United States.
11. It provides for a State-wide study of health needs which should lead to the discovery and effective use of existing resources. Few States have as yet set up the machinery for a continuing study and evaluation of existing health resources and still fewer States have developed a planning board to formulate plans for meeting the health needs of the future.
12. Federal aid is offered to the States by methods which do not weaken the moral sense of responsibility in either the individual or the community or the State as a whole. The language of the bill calls for cooperation and not for coercion, for participation instead of

police methods. and for mutuality of effort rather than regulation by bureaucratic manifesto.

13. Local control, coupled with voluntary participation, would, in all probability, provide the country with a national health program much easier to operate, a good deal more efficient and far less expensive to maintain than the compulsory system advocated by the sponsors of socialized medicine.

14. The language used in titles VII and VIII on pages 21, 26, and 34 of the bill reveals a respect for the authority of the States and a desire for administrative flexibility in achieving defined objectives, that is consonant with American traditions and democratic procedures

15. Since it seeks to avoid bureaucratic regimentation and, at least indirectly, encourages what Dr. Frank H. Lahey of Boston has called "quality competition" in all branches of the private practice of medicine, this bill will tend to prevent the blight of bureaucratic mediocrity and buck-passing that has always retarded development in our State hospital systems for the care of the mentally ill, in our public school systems and, until very recently, in our Veterans' Administration. With our State hospitals popularly labeled as "snakepits" and the "shame of the States" and with teachers deserting their jobs and their profession by the tens of thousands because of senseless regimentation, starvation salaries, and intolerable insecurity, it does not seem advisable to put medicine in the same kind of a collectivistic strait-jacket.

Now that brings me to the third part of my testimony, which consists of a few specific recommendations for amendments, and if you wish, I shall present them as outlined here in detail or, if you wish, I will just turn them in with the statement.

Senator Smith. You might give us just the substance of them, Doctor, so that we can understand what they are.

Dr. Murphey. In substance, we feel that this bill should be modified or amended in such a way as to put in control of the administration of a national health program men or women who are professional people, with sound, seasoned experience in the field of private practice. America was built by private endeavor. The medical profession has reached the place it now occupies in America through private initiative, and we should like to see the health program of this country guided and stimulated by people with that kind of experience. We trust them and feel that their living and their way of thinking is consonant with the way of thinking generally prevailing in this country.

So we have emphasized in several places that the director himself and various other people who come in here shall have a great deal of private practice experience. Another thing that we have emphasized here is that men appointed to the directorship in the various councils shall be men not otherwise in the employ of the Federal Government. We think that is a wise provision because it would prevent these councils being packed with governmental employees who have, we grant, an idealistic attitude toward medicine but who are lacking in sympathy for the problems of the private hospital and the problems of the private doctor.

Senator Smith. Doctor, what relation, if any, do you feel that the health program would have to the general social security program? Do you think they are related, so they should be handled together, or do you think the health program is such that it should be handled independently?

Dr. MURPHEY. I feel it should be handled independently, sir, because the management and direction of a health program calls for medical experience rather than social worker experience or the kind of experience that perhaps would be very helpful in a social-security program.

Senator SMITH. If we are seeking to take care, as we do both in this bill and in Senator Murray's bill, of the problem of people in the low-income group—and we have to determine what groups we want to cover by our medical help, whatever it may be, Blue Cross premiums, however we may decide to handle it—should the group of persons to be assisted be determined by a health authority or should they be determined, in your judgment, by the social workers, etc.?

Dr. MURPHEY. I think there has to be some method of finding out accurately who needs help and how much help they need, and in that sense, I think there should be some relationship between social security, on the one hand, and health on the other hand.

Senator SMITH. We don't like the expression "means test," but in the last analysis, if we are going to find out who should be helped or who ought to pay at least part of the medical service, we ought to have some kind of test to work that out. I mean I don't feel the way many people imply that you have to have a "means test." I don't think it is true at all. In all our State organizations we have had to determine in our society for whom society has responsibility. You suggest in your statement of principles here that there is a point at which society does become responsible. We recognize that. We have to have some way of finding out the area that needs that aid.

We speak of the classifications of the absolutely indigent and the so-called medically indigent. We have had a lot of testimony along the line of classifying those groups, and I am seeking some formula to determine how to classify those people so that the service rendered isn't imposed upon them. I think Senator Murray's view is, if we have an over-all insurance plan, we will not have to regard those distinctions if we do it by that route. That is one of the big issues before the committee, trying to determine the most effective way to do it.

Dr. MURPHEY. We have a means test in Colorado and we believe in using it not only in Colorado but throughout the Nation. A means test is essentially a needs test to determine the individual's needs and his resources, and by comparison of the two you arrive at his means, the means which he has available to take care of his health protection.

Now, I see no reason to stutter or stammer at all at the word "means" or "means test." That is a very well established principle. We carry that out in our income-tax situation. People pay and support their Government according to their means. We believe that there is nothing at all about the means test that carries with it the implication of unworthiness or charity at all.

We would like to emphasize, sir, this fact: People today in many situations talk about their rights, their right to health. Well, we deny that people have such a right at all. We insist that people only have the right to earn their food, shelter, clothing, and health protection. We grant, of course, that there are people disabled who cannot earn. There are people sometimes in situations where they cannot do that. We give them aid not because they have a right to it but because society has a moral obligation to look after them. I think it is a matter of how you use the word "right" and how you use the word "obligation."

Senator SMITH. You think everyone should be expected to contribute by producing his part of the national economy?

Dr. MURPHEY. That is right.

Senator SMITH. And to protect the person's opportunity to earn a living is the extent of government responsibility except in those cases where, perchance, a person may be incapacitated due to no fault of his own?

Dr. MURPHEY. That is my deduction. I think in our country, we want people to earn their own way. We believe that compulsory health legislation or any other program that leads the people of America to believe they have rights which they do not in fact have is a kind of social tinkering that is rather mischievous. What we need, I suppose, is more opportunity for people to earn what they need.

Senator SMITH. Doctor, I notice in the opening of your statement you say that this United Public Health League was organized in 1944 and it includes the State medical associations in Arizona, California, Colorado, Idaho, Nevada, and Utah. I would be interested in a brief statement from you as to why that group of States set up this so-called United Public Health League. Was there some feeling of need to cover some lack of medical care in those areas? Was that the motive?

Dr. MURPHEY. Yes, sir; at that time. There is a kind of community feeling between people in the Rocky Mountain area. Some of us got together and out of that coming together informally emerged the United Public Health League. We felt that the interests of private practice and private hospital administration were being somewhat threatened, indeed, greatly threatened, by what we thought to be an unsound movement in the direction of compulsion. So we got together and organized ourselves into a league and hired a representative to be here in Washington to tell us what was going on and to keep us informed.

Senator SMITH. You have a representative in Washington?

Dr. MURPHEY. We do; yes, sir.

Senator SMITH. Can you give his name for the record?

Dr. MURPHEY. We have here Mr. James J. Boyle and Mr. Ben H. Read as our representatives. I believe those names are in my statement.

Senator SMITH. I assume, Doctor, that you are offering your statement and all these appendixes for the record giving these names. I would very much like to have those in the record.

Dr. MURPHEY. That is right, sir. They are in the record, sir.

Senator SMITH. Now let me ask you this further question: You presented to us a set of very interesting principles and also your comments on S. 545 and criticisms of it. Are those the result of meetings of any of your committees or are those your own personal views?

Dr. MURPHEY. They are the result of the meeting of the United Public Health League at their last meeting in Salt Lake City. They reflect their decisions and also the action of the board of trustees of the Colorado State Medical Society.

Senator SMITH. Then these reflect the views of both the Colorado group and the larger group of the States which you have mentioned.

Dr. MURPHEY. That is right.

Senator SMITH. I notice California is included. We have had some discussion here as to what the views of California are, and apparently there is some difference of opinion in California, as was brought out in the last 2 days. There were some of the doctors that were against national compulsory health insurance and there were others who feel it would be desirable. We had a message from the AFL in California saying they supported the compulsory program and I have had other suggestions that Governor Warren supports the compulsory voluntary program while others oppose it. So we are rather left with the idea that California has a difference of opinion on it. Have you any comments to make on the fact that California is one of the group of States that you represent?

Dr. MURPHEY. I am certain that we are accurately reflecting the thinking of the California State Medical Society. There may be individuals who differ with their position, but we do represent their views in this statement.

Senator SMITH. And the California State Medical Society is representative of the bulk of the doctors of California?

Dr. MURPHEY. The vast majority of the practitioners in the State of California.

Senator SMITH. Are there any official figures on that?

Dr. MURPHEY. I have no figures on the State of California. I doubt if they have them even in California.

Senator SMITH. Well now, Doctor, I notice in your appendix 3—I am interested in this because I lived in Colorado for some time; we have had a lot of testimony on the so-called Blue Cross plan. I would like to have a little comment from you on what you call the hospital service. That question particularly was brought out by other witnesses as to whether the hospital service, the Blue Cross plan in Colorado, includes anything except just hospital service or whether you get any medical and surgical assistance or whether you have any general medical service under any voluntary insurance plan.

Mr. MURPHEY. In appendix 3, I have pointed out the few simple facts about our Blue Cross Plan in Colorado, indicating its size and its rate of growth and membership, and so forth. Then in appendix 4, on the next page, I have tried to do the same thing in regard to Colorado Medical Service. Colorado Blue Cross Plan, of course, provides only for hospital care; Medical Service, on the other hand, provides for certain medical service to those who are members of the Plan.

Senator SMITH. Is that what corresponds in Massachusetts to the Blue Shield program? Massachusetts has a Blue Cross for its hospital service and a Blue Shield for the other service, and I am wondering whether in Colorado that corresponds to the Blue Shield work.

Dr. MURPHEY. Yes; that is right.

Senator SMITH. I haven't read that through yet. Is that a voluntary insurance plan?

Dr. MURPHEY. That is right.

Senator SMITH. So that people pay premiums for certain coverage.

Dr. MURPHEY. That is right, sir.

Senator Smith. Do you consider that that Colorado Medical Service, as it is called, is an over-all coverage or a limited coverage?

Dr. Murphey. Well, like all other programs of this nature, it is somewhat limited, of course. We have had no complaint about it. It is growing very rapidly.

Senator Smith. Senator Murray, do you want to ask the witness some questions?

Senator Murray. Yes. I am greatly interested in your very carefully prepared statement and many of the points that you have made here. I am particularly interested in that statement of yours to the effect that no one has the right to health, that the only right they have is the right to earn the means by which they may protect their health, secure shelter and food, clothing, and so forth.

In your statement on page 3, the second paragraph from the bottom reads as follows:

> In a free society most real wealth and all goods and services are primarily the product of individual initiative and personal effort. It follows, therefore, that a national health program consistent with this way of life must encourage the individual to provide health protection for himself and his family through his own effort.

Now your statement, of course, is based on the idea that this economy we operate under is a free-enterprise system. You recognize, of course, I suppose, that our economy has been completely revolutioned during the last 50 years. Isn't that true?

Dr. Murphey. Well, we recognize there are many people who want to completely revolutionize it.

Senator Murray. But hasn't it been revolutionized by business itself? Don't you think that the result of the growth of monopoly and concentration of ownership in this country has had that effect? Do you think that effect has been brought about by long-haired New Dealers in this country and that they are the ones that created this concentration in industry and monopoly? You don't accuse us New Dealers of that, do you? [Laughter.]

Dr. Murphey. We recognize that changes are taking place.

Senator Murray. Well, haven't they already taken place? Isn't this country now just a few theoretical steps behind the kind of an economy they had in Germany before the war?

Dr. Murphey. I hope not, sir.

Senator Murray. I hope you could be right, but the best economists in this country take that attitude. Now Fortune Magazine, which you can't claim is a New Deal magazine, made a very thorough study of this in 1938, and they pointed out then and there that this country had progressed so far along those lines that it was just a little ways behind the kind of economic conditions they had in those European countries. You will find that article in the Fortune Magazine for March 1938. A whole series of studies was carried out during that year. Now Fortune Magazine in the last issue just out a few days ago has another complete study of the proposition and points out that our country has completely changed during this time. Concentration of ownership in business has gone to such a degree that it is mighty difficult for an individual nowadays to be able to protect himself like we could have back in the horse-and-buggy days. So that we have been compelled to introduce all sorts of controls in this country.

All of these bureaus that you see scattered over the city of Washington have been brought here by big business. Isn't that true?

Dr. MURPHEY. I think that perhaps many of the bureaus——

Senator MURRAY. Yes, it is absolutely true. No one can deny that. Take the Securities Exchange Commission. Take the Federal Power Commission. Take the Interstate Commerce Commission. Take the Federal Trade Commission. Take practically every bureau that we have in Washington. Practically every bureau that we have in Washington has been brought here by big business. Isn't that true?

Dr. MURPHEY. Well, I would put it this way, Senator, that there is a tendency in our time for individuals to exercise relatively little control over themselves, which begets in government the need for government to exercise the power which the individual refuses to exercise. However, that fact does not justify a monopoly either in government or private business. It does not justify regimentation in either direction.

Senator MURRAY. I think you have got the cart before the horse there. Here is the real truth of the matter, Doctor, that it was the concentration of business and industry in this country that brought these conditions into effect and brought us to the present state of affairs. It was not as a result of individuals seeking to set up a monopolistic or collectivistic government here in Washington. The economists point out that concentration in business begets concentration in government. You can't have an industry such as United States Steel, for instance, that employs practically a million men and has an investment of billions of dollars and regard that as a purely private concern.

Dr. MURPHEY. Senator, we like the viewpoint of your neighbor and my neighbor, Senator O'Mahoney of Wyoming, who insists he doesn't want monopoly either.

Senator MURRAY. That is right. I agree with Senator O'Mahoney. I, too, have been trying to block monopoly, but we have failed in this country. Concentration has gone on more rapidly during this war and immediately following it than it had in all the years prior thereto. So that, as I point out to you, things are totally different today in our country than they were 40 or 50 years ago. Of course, I will grant you that in your State of Colorado, and perhaps in my State of Montana, we can find some way of digging in and taking care of ourselves in these emergencies, but we had a terrible time during the last depression and there is another one now in the offing, they tell me, that is going to try us very severely again.

Now, the point I want to make is that it is mighty difficult for the individuals today who are employed in these great industries in our country and concentrated in these big cities to protect themselves and to protect their health and to get the means whereby they can have good health, good education for their children and good care for their families. It is a very, very difficult job, I will tell you, and if you were an ordinary workingman in some of these big industrial centers, you would appreciate it, I am sure. I know the situation in the mining industry in my own State of Montana; it is getting worse everywhere because of this gradual concentration and development of monopoly in the country.

Some means must be developed whereby the health of the people of this country can be protected a little more than it has been in the past.

The average individual with an income of a few thousand dollars a year cannot buy the medical care that he needs for himself and his family, and no citizen wants to go on record, if he can avoid it, of admitting that he is a second-class citizen, that he isn't able to make his way in the world; that is a system that American people don't like, and we must find some way of making it possible for people to get good health in this country without having to admit that they are paupers.

Now that is all my bill is designed to do. We may have some mistakes in it. That is what these hearings are for. Have you seen the latest bill that has been filed here in the Senate?

Dr. MURPHEY. No, sir; I haven't had an opportunity to see it, Senator.

Senator MURRAY. Well, in that bill, we have sought to get away from many of the criticisms that were made during the last few hearings that we have had, and we have sought to decentralize administration and place it in the control of the States, with the medical profession having a voice in how it is to be administered. We are not undertaking to set up bureaucrats in Washington to tell you the kind of medicine you are going to have or anything like that. The bill is just an effort to bring about a real democratic system of national health insurance which will enable all people to get the kind of medical care they should have for the protection of themselves and for the welfare of the country as a whole. That is all it is.

I will be glad to furnish you with copies of that bill and an abstract of it so that you may take it and give it your study.

I notice in your testimony, Doctor, on page 8, paragraph 15, that you made an analogy there of the public-school system with the medical problem. Now the principal difficulty with the public-school system in this country is that it hasn't been adequately financed and the salaries of the teachers haven't been adequate to get the best teaching staffs in the country. Isn't that true?

Dr. MURPHEY. That is only part of the reason, I think, Senator, the other part being due to the fact that school boards, particularly in rural areas, are likely to be very arbitrary and dictatorial so that teachers have very little security, very little personal freedom and the profession has become increasingly unattractive. Actually, according to the NEA—the National Education Association—out of 900,000 teachers in this country in the last 5 years, more than a third, 350,000 teachers, have left the profession. In our State of Colorado, for example, we had approximately 9,000 positions in the school year 1946–47, and we could not get teachers to fill those positions, so that we were required to give the positions to people who were unqualified. We had to issue emergency certificates to 2,500 out of somewhat less than 9,000.

Senator MURRAY. Well, that is happening all over the country.

Senator SMITH. I might say there, Senator, in that connection that Senator Aiken of this committee is chairman of the subcommittee on education and we have been considering a bill to take care of that very problem that you have presented to us which will help the weaker areas in this country in their school problems by Federal grants-in-aid under principles similar to the Federal grants-in-aid in S. 545.

Dr. MURPHEY. I mention this simply because the assertion is constantly made that health could be put on the same basis as education.

Well, I should hate to see the health of the United States handled as the education problem is handled.

Senator SMITH. I think we all agree on that.

Senator MURRAY. I would hate to have our medical-care program in the same situation as the educational program is now.

Dr. MURPHEY. We have a more analogous situation in the field of our State hospitals for the care of the mentally ill, and that is socialized medicine. It has existed for almost 100 years in this country, and anyone who will take the trouble to inquire into the status of the patient and the status of the doctor in the average or typical State hospital for the care of the mentally ill in this country will be shocked indeed to find that the patient, on the one hand, gets stereotyped assembly-line care—there are exceptions to this, of course—and that the doctor who works on that is so involved in red tape and political intrigue and so utterly lacking in security in his job that he becomes a sort of a rubber stamp, yes-yes man.

Now I should hate to see all of medicine follow in the path of medicine as it is practiced in our State hospitals for the care of the insane, and I have seen no reason brought forth by anyone to convince me that that wouldn't eventually happen if we bring compulsion and regimentation into the health field.

We would like to have our representatives in Washington, our Senators and our Congressmen, join with Senator O'Mahoney in making a country where the abuses of the monopolies are eliminated not only in business, but also in Government, and then, we think, medicine would get along very well and people would have good health care.

Senator MURRAY. I agree with you on that, but that is an impossible job. There is no way now that we can retrace our steps and decentralize in this country. There is no way now that we can dispose of the big monopolies. We have gone so far along this line that a Presidential candidate, Mr. Stassen, has stated that the only thing we can do now is to regulate them and control them. He said that in his statement here just the other day. Everyone recognizes that now our economy has become collectivized. We have got a collectivized economic system in this country and it is difficult to change it now. You have millions of men centered in these big industrial areas who are absolutely hopeless when a depression comes on. They and their families are never able to accumulate enough savings to be able to take care of a catastrophic illness. If a sickness hits their family, they have to go into debt or go without the care, as a general rule, unless they can get charity in some of the centers of the country.

I agree with you that we have got to have some kind of relief for those people that can't afford to pay, but I am trying to develop some manner by which they can get it and hold their heads up and feel that they are paying their way, that is all.

Dr. MURPHEY. Senator Murray, we feel the fact that our Nation having gone perhaps dangerously far in the direction of collectivism in business, on the one hand, and in Government, on the other, cannot possibly justify our going still further on that wrong road. We think that the thing to do is to turn around and go back, not in the sense of turning back the hands of the clock, but in the sense of going back to sound principles of democracy.

Senator MURRAY. I wish we could do that. If you could work out a program of that kind, I would recommend you to be a cabinet officer here in Washington [laughter] and put you in complete charge. I appreciate your testimony, Doctor. Notwithstanding the fact that I have put these questions to you, I realize that you, like every other doctor in the country, are greatly interested in this problem. I am very sorry that I have to advocate this kind of program, because I can see how it affects the minds of the medical profession, yet somebody has got to bring these questions before the American people and let them work out some kind of program. Something has got to be done about it, and I appreciate your coming here and I appreciate the statement that you have given us.

Senator SMITH. Doctor, I just have one or two more questions. I hope you will read Senator Murray's bill, S. 1320. We can furnish you with a copy of it. There is one provision in it that I would like to ask you about because it has to do fundamentally with the setup of the control of the health program.

On page 38 of Senator Murray's bill, in section 251, there is this provision: "There is hereby established in the Federal Security Agency a National Health Insurance Board, referred to in this title as the board, to be composed of five members, three of whom shall be appointed by the President, by and with the advice and consent of the Senate, and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner of Social Security. At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States and none of them shall engage in other business, vocation or employment."

Now this is an over-all bureau within the Federal Security Agency. I asked you a little while ago whether you felt that the health program should be a part of the over-all security program or whether it should be independent, and I understood you to say that you thought it should be independent.

I just call your attention to this provision in the bill. I am not criticizing it at all. I just say this proposal in the so-called Murray bill, S 1320, plans to set up this National Health Insurance Board in the Federal Security Agency, and of the men on that board, three are appointed by the President, two are laymen or could be laymen and only one has to be a doctor, and the other two members are the Surgeon General of the Public Health Service and the Commissioner of Social Security. It is part of the Federal governmental program.

I admit that I don't feel it is the right set-up, but I just call it to your attention in studying this bill, and if you are able to comment on it, I know Senator Murray and I would be very glad indeed to have your comments either for or against the provisions of this bill. I am not trying to prejudice you one way or the other. I am just calling attention to the set-up proposed.

Dr. MURPHEY. Well, not having read the bill and not knowing the context of that particular part which you selected, I am at a disadvantage in commenting on it, but I would say this, that we would think it very unsound indeed to make it part of a Federal agency. We believe that medicine is entitled to a cabinet position and that all matters pertaining to health should be in one department and that the whole thing should be supervised and directed and, in some measure, controlled by doctors. We recognize that the consumer has rights, too, and we would like to provide that he be represented in such an establishment. However, that is my own personal reaction and I cannot speak for either the Colorado State Medical Society or the United Public Health League.

Senator SMITH. I understand that.

Dr. MURPHEY. No; I would not favor that.

Senator SMITH. Well, I would like very much to have your thoughts on that. Now with regard to this whole question of whether we should centralize medical practice further, maybe the time will come when we shall do so, but I would like to call your attention to the report made by the New York Academy of Medicine in the book entitled Medicine in the Changing Order, where this whole matter was considered: compulsory insurance plan, voluntary plan and the question of progress by an over-all program blueprinted ahead of time or a State by State progress toward results by the trial and error method. We were discussing those from different approaches.

I want to read their statement in their report on page 218 and see whether you would agree with it:

> The problems which compulsory national medical insurance engenders appear so formidable, and the evils it threatens so plain, that the Committee strongly advises against hasty action. Once the country commits itself to this type of policy and legislation, it cannot retrace its steps. Valuable and promising experiments to solve the problems in other ways will be abandoned because everyone will be busy setting up a massive new administrative machinery and distributing huge funds. The long record of experience in foreign countries shows that the problems and difficulties encountered in administering these plans are rarely disposed of satisfactorily. When they are dealt with at all, it is usually by means of a patchwork of amendments and executive orders which rarely go to the roots of the trouble. "Insurance institutions are usually built in haste and patched ever after."

Dr. MURPHEY. I certainly say amen to that and agree with it.

Senator SMITH. As I said to Senator Murray, I would be very happy personally if some States wanted to try it on an experimental basis, as sort of guinea pig experiment. I have no objection to that. I think Senator Murray would share the view that he would like to see some State try it that way, but take New Zealand, for example, which has a population of less than 2,000,000, where the compulsory plan works, and set that up as an example, and compare with this country, where we have 140,000,000 people, where we have 48 States, with all sorts of diversities, and throughout all our history we have kept our State independent in the decentralization of running things from the very beginning because we were dealing with different points of view, and the independence of thinking people in the separate States were a valuable asset also in the progress of our country's history.

I have taken the strong position that the way to deal with this is to decentralize to the States and tell the States: "go ahead and try such plans as you see fit, we will not impose upon you an over-all program of compulsory insurance, and we don't know what will happen if you try it as an over-all experiment."

Senator MURRAY. My only comment on that is that I agree that any medical program that is set up should be decentralized and the States should be entitled to set up the kind of program that they think should be carried out in each State. The only purpose of the national administration is to provide the standards of quality and to provide efficient collection and distribution of funds through the National Government. The States should comply with standards of care, standards which would be under the control of the medical profession itself. The medical profession could determine the character of medical care and hospitalization that the States should carry on.

I agreed with that and I agreed also with you, Doctor, that any program set up in the country should be under the direction of a Cabinet officer in this country. I thought we should have a Cabinet officer in charge of health in this country. Health seemed so vastly important to the people of this country that we should have a separate department for it here. However, in this bill we have put it in the Federal Security Agency because we've found it inextricably involved with finance, social insurance, and welfare. That doesn't mean that Social Security is going to run medicine.

Senator SMITH. Doctor, I would like to add one more comment, and this is from a publication of the International Labor Office, the well known ILO. It is a document entitled "Approaches to Social Security, an International Survey." This quotation is from page 50:

> The fact is that once the whole employed population, wives and children, included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities, on the other.

Dr. MURPHEY. And may I add that it also squeezes out competency more and more and more; everybody becomes a pawn.

Senator SMITH. Well, that would seem to me to be the logic of it, but I just want to try to get before you and your colleagues the issue we are trying to discuss here and the different approaches to this overall health program.

I am very grateful to you, Doctor, for the splendid statement you have given us and the contribution you have made to our discussions.

Senator MURRAY. Mr. Chairman, may I have these two statements follow the doctor's testimony?

Senator SMITH. Senator Murray asks to have two statements incorporated in the record following Dr. Murphey's testimony.

(The two statements submitted by Senator Murray are as follows:)

### UNITED PUBLIC HEALTH LEAGUE, POINT II

Mr. Chairman, I should like to read into the record a short statement made by Mr. John Hunton, executive secretary of this Public Health League. It concerns the proper tactics to use in winning friends and influencing the right people. Mr. Hunton was advising other medical societies how things are done in California. Here's what he had to say:

"At present the California Medical Association is spending $100,000 a year in newspaper advertising * * * it has done something which we have never before been able to accomplish in the State. We have 700 newspapers, a great many of them small weeklies. Never before have we been able to get real support from the newspapers, because the answer constantly comes back: "Why should we give the doctors any support when they don't advertise and chiropractors do?" We now have an answer to that. When we started our campaign we went to the California Newspaper Publishers' Association and said: "Gentlemen, we are going to spend a lot of money with the newspapers. We are going to advertise in every one of the 700 newspapers in California: * * * We have found the response from the editors, in publicity, has been far beyond anything we expected when we started the campaign." (Quoted in Journal of the American Medical Association, March 5, 1947, p. 628.)

## UNITED PUBLIC HEALTH LEAGUE, POINT III

Mr. Chairman, I'd like to place in the record at this point a copy of the Washington Letter of the United Public Health League for May 9, 1947. I won't read it now, but I am sure that all the members of this committee will find it of interest.

## WASHINGTON LETTER

THE UNITED PUBLIC HEALTH LEAGUE,
*Washington 6, D. C., May 9, 1947.*

### TAFT BILL HEARING SET—V. A. PROGRAM—LOBBYISTS REPORT

### *Hearings scheduled on Taft bill*

Dr. Shearon has been given the green light by Senator Smith, permitting her to go ahead with the arrangements for the hearings on S. 545 beginning May 21. Because of differences of opinion over some statements she has made in her bulletins, she has agreed to discontinue the bulletins.

Dr. Lowell S. Goin is scheduled to appear June 4 to represent the California Medical Association and California Physicians' Service. Dr. Bradford Murphey will appear June 6 to represent the United Public Health League.

There are 47 witnesses scheduled, so it looks like a long-drawn-out affair.

Senator Smith, chairman, did not attend many hearings last year on the Wagner-Murray-Dingell bill, hence is not too well posted on the problems in connection with health care. It is said he will depend a good deal on the New York Academy of Medicine for help.

### *Wagner-Murray-Dingell bill*

The 1947 Wagner-Murray-Dingell bill will be introduced about May 12. It is said to contain many modifications in favor of State autonomy. The bill is expected to be heard following the Taft bill, S. 545.

Members of the Senate Subcommittee on Labor and Public Welfare, before whom the bill will be discussed, are Smith, chairman; Ball, Donnell, Murray, Pepper.

### *Congress at the halfway mark*

Economy moves in Veterans' Affairs, it is feared, will reduce the quality of Veterans' Administration medical care to its previous status of 1945.

A current wave of low morale among the professional staff of the Veterans' Administration is said to be alarming and is reaching down to patient morale. New buildings are being constructed and money is freely allowed for this, but not so when it comes to medical service and the hiring of necessary personnel—that is the complaint heard in Veterans' Administration circles.

Congress is now in session 4 months, with 3 months to go for the first half of the Eightieth session. The party issue is becoming more pronounced as both sides square away for the final punch. All the important legislation still faces the membership.

The budget has been cut one billion one hundred million, with no sign of the House six-billion cut in evidence. Further extensive cuts cannot be accomplished without disturbing agriculture, Army, and Navy to the extent of creating a political disaster.

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(The brief, including appendixes, submitted by Dr. Murphey is as follows:)

## STATEMENT OF THE UNITED PUBLIC HEALTH LEAGUE OF AMERICA AND THE COLORADO STATE MEDICAL SOCIETY

Mr. Chairman and committee members, for the record let me say that my name is Bradford Murphey, member of the board of directors of the United Public Health League of America and chairman of the board of trustees of the Colorado State Medical Society. I appear here as the representative of the United Public Health League and the Colorado State Medical Society.

The United Public Health League was organized in Salt Lake City, Utah, on January 29, 1944, at a meeting of the legislative chairmen and officials of the

State medical associations in Arizona, California, Colorado, Idaho, Nevada, and Utah. It is a voluntary, nonprofit cooperative association. Its purposes, as set forth in its constitution and bylaws, are as follows:

(1) "To educate the public to the proper evaluation of medicine, dentistry, nursing, and the allied health sciences;

(2) "To make social, economic, and other studies pertaining to the preservation of the public health and the care and treatment of the sick and injured;

(3) "To gain the enactment of Federal legislation effecting the greater usefulness of ethical medicine, dentistry, nursing, and allied health sciences;

(4) "To protect the public health, particularly by suggesting and supporting desirable forms of medical, dental, and public-health legislation submitted to the Congress of the United States;

(5) "To protect the public against quackery and patented nostrums, fraudulent advertising, and the medical practices of unqualified persons and groups;

(6) "To support those agencies having public-health duties and functions in their efforts to reduce the prevalence of disease and disability and to promote the health of the people; and,

(7) "To protect qualified persons, institutions, and agencies, engaged in the care and treatment of the sick, against unjust encroachment upon their functions and activities."

The United Public Health League is a simple federation of State medical associations. It is not a propaganda or publicity organization. It operates as a liaison agency between the medical associations within its membership and the various branches of the National Government. It acts nationally in the same manner that the legislative committees of State medical, dental, and allied organizations work within their own States.

Membership in the league is by State medical associations rather than by individual physicians. The aggregate membership in the State medical associations which make up the United Public Health League at this time is approximately 12,250 physicians or slightly less than 10 percent of the total number of physicians in the Nation as a whole (see appendix I).

The Colorado State Medical Society was organized on October 31, 1888, "to promote the science and art of medicine and the betterment of the public health." At the present time the society has 1,250 active members or about 85 percent of the practicing doctors of medicine in the State. Its policies are determined, and its officers and board of trustees are elected, by a house of delegates which represents the county and district component societies in proportion to their membership. The house of delegates meets at least once each year. When it is not in session the society is governed by its executive officers and a board of trustees (see appendix II). Under these officers the society conducts its business through 13 standing committees, 9 public-health committees, and 12 special committees.

The Colorado State Medical Society owns the Rocky Mountain Medical Journal, a monthly publication, and operates it on a nonprofit basis jointly for itself and for the State medical societies of New Mexico, Utah, and Wyoming, as the official journal for these four medical societies and also for the Rocky Mountani Medical Conference and the Colorado Hospital Association.

This testimony will deal with three principal topics:

1. Principles to be observed in the development of a sound national health program in a free, democratic society;

II. Acceptable features of Senate bill 545; and

III. Criticism of certain provisions of the bill and some suggestions for its amendment.

## PRINCIPLES TO BE OBSERVED IN THE DEVELOPMENT OF A SOUND NATIONAL HEALTH PROGRAM IN A FREE, DEMOCRATIC SOCIETY

(1) In a free society most real wealth and all goods and services are primarily the product of individual initiative and personal effort. It follows, therefore, that a national health program, consistent with this way of life, must encourage the individual to provide health protection for himself and his family through his own effort.

(2) A free, democratic society does not guarantee the right to free shelter, free clothing, free food, or free medical care. On the contrary, if a society is to stay free, it can only guarantee the right to be free to earn such goods and services.

(3) A sound national health program in a truly democratic society, therefore, must recognize the social obligation of every individual citizen to provide through his own effort for his health protection insofar as his means, his social circumstances, and his physical ability will permit.

(4) In a free society individuals or groups of individuals must be left free to provide for their own health protection by methods of their own selection, providing the methods selected do not restrict the rights of others through the use of force or compulsion.

(5) While the individual has no inalienable right to free health protection, it must be recognized that society has a moral obligation to assist him in the protection of his health in all those public-health situations where the individual is powerless to act effectively alone and also where, as the result of poverty or personal disability, he cannot provide protection for himself.

(6) While society has a moral obligation to assist the destitute and the disabled in matters of health protection, it has an even greater obligation to do this in a way that will increase the individual's appreciation of his own obligations and by methods that will not make him increasingly irresponsible and dependent upon the state.

(7) To be compatible with our American way of life a national health program must strengthen existing free health institutions, agencies, methods, and procedures, by stimulating voluntary cooperation on the part of individuals and groups. For exactly this same reason, it must also avoid all forms of compulsion since such compulsion inevitably fosters social regimentation, destroys individual initiative, and thus impairs the quality of medical skill and service.

(8) To fit our American concepts of democracy a national health program must also preserve the freedom of personal relationship between patient and doctor—the patient's freedom to select his own doctor and the doctor's freedom to choose his own patients.

(9) Since most of the illness in the world today is psychosomatic in nature, at least to some degree, and since all phychotherapy depends upon a free and comfortable doctor-patient relationship, it follows that any form of compulsion in the doctor-patient relationship, or even any depersonalization of this relationship by assembly-line methods, must inevitably bring about a rapid deterioration in treatment results.

(10) In this connection, it must be recognized that while health is important, it is not as important as freedom, either for the individual or for the group. Health for its own sake, without dignity and freedom, is not only a false value but actually an impossibility since the lack of freedom destroys the mental, emotional, and moral health of the individual and the group.

(11) And finally, it is important to remember that a sound national health program cannot be built upon the false assumption that the end always justifies the means. No end, however important—not even life itself—can possibly justify the use of such means as are advocated by the proponents of compulsion. Voluntary methods may at times be exasperatingly slow but at least they do not destroy human values such as freedom and personal responsibility and they do develop the capacity for cooperation and thus strengthen human character.

### ACCEPTABLE FEATURES OF SENATE BILL 545

In general, both the aims and the methods advocated in Senate bill 545 are in accord with the principles set forth above. We urge its passage because:

(1) It provides for a voluntary, rather than a compulsory, national health program. Individuals and groups of all kinds are left free to accept it or reject it. It does not force those who can pay for services—and who desire to do so—into a bureaucratic Federal system.

(2) Its provisions permit the full voluntary use of private agencies such as our medical service and hospital service plans whose rapid growth demonstrates both their undoubted success and their acceptability to our people (see appendixes III and IV).

(3) The indigent and medically indigent are provided with a free choice of doctors—and the doctor is left free to choose his patients.

(4) It provides the authority necessary to offer medical service and hospital service plans to several millions of Federal employees.

(5) It will probably encourage students of the right caliber to enter the medical profession since it permits enough free competition to reward competency and enough personal freedom to make the medical profession attractive.

(6) Hospital construction will undoubtedly be facilitated in rural areas by this bill. At the present time many rural areas cannot afford the full cost of hospital construction. By carrying a part of this load, the bill will increase the availability of hospital resources to all of our people.

(7) Its provisions will tend to restrict the activities of the United States Public Health Service strictly to the field of public health and not only keep it out of partisan politics (we hope) but also keep it out of the field of active medical practice.

(8) In a similar manner it will tend to concentrate the activities of the Children's Bureau in the area in which the Bureau was originally intended to operate.

(9) It provides that the director of the office of Medical and Hospital Care Services must be a doctor of medicine with at least 5 years of active medical practice and who is outstanding in the field of medicine. This provides at least some measure of protection against the arbitrary directives and immature judgments of the inexperienced and impractical type of idealist, occasionally found in some of our governmental health bureaus and agencies.

(10) It very wisely provides that the actions and decisions of the Director of the office of Medical and Hospital Care Services shall be subject to review by the United States courts and, if necessary, by the Supreme Court of the United States.

(11) It provides for a State-wide study of health needs which should lead to the discovery and effective use of existing resources. Few States have as yet set up the machinery for a continuing study and evaluation of existing health resources and still fewer States have developed a planning board to formulate plans for meeting the health needs of the future.

(12) Federal aid is offered to the States by methods which do not weaken the moral sense of responsibility in either the individual or the community or the State as a whole. The language of the bill calls for cooperation and not for coercion, for participation instead of police methods, and for mutuality of effort rather than regulation by bureaucratic manifesto.

(13) Local control, coupled with voluntary participation, would, in all probability provide the country with a national health program much easier to operate, a good deal more efficient and far less expensive to maintain than the compulsory system advocated by the sponsors of socialized medicine.

(14) The language used in titles VII and VIII on page 21, 26 and 34 of the bill reveals a respect for the authority of the states and a desire for administrative flexibility in achieving defined objectives that is consonant with American traditions and democratic procedures.

(15) Since it seeks to avoid bureaucratic regimentation and, at least indirectly, encourages what Dr. Frank H. Lahey, of Boston, has called "quality competition" in all branches of the private practice of medicine, this bill will tend to prevent the blight of bureaucratic mediocrity and "buck passing" that has always retarded development in our State hospital systems for the care of the mentally ill, in our public school systems and, until very recently, in our Veterans' Administration. With our State hospitals popularly labeled as "Snake-pits" and the "shame of the States" and with teachers deserting their jobs and their profession by the tens of thousands because of senseless regimentation, starvation salaries, and intolerable insecurity it does not seem advisable to put medicine in the same kind of a collectivistic strait-jacket.

## CRITICISM OF CERTAIN PROVISIONS OF THE BILL AND SUGGESTIONS FOR ITS AMENDMENT

(1) The language used in section 2, paragraph (c), specifying "that it is the policy of the United States to aid the States, through consultive services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status" is unfortunate to say the least. Individuals who are economically able to pay for such services, in whole or in part, should be required to do so and we suggest that the bill be amended accordingly.

(2) The language on page 24, section 715, paragraph (b) does not provide that the council consist of "persons not otherwise in the employ of the Federal Government." This wise provision is included with respect to the Dental Health Council and we most emphatically advise that it also be included in the provision

for the National Medical Care Council. To omit this provision would leave the door wide open for the appointment of certain careerists, lacking in sympathy if not actually hostile, to the needs of private institutions and the problems of private practice.

(3) We also recommend to the committee that the language on page 24, section 715, paragraph (b) which states that, "Five of the eight appointed members (of the council) shall be persons who are outstanding in fields pertaining to medical and hospital care, at least four of whom shall be doctors of medicine" be amended as follows: "Six of the eight appointed members shall be persons who are outstanding in the fields pertaining to private medical practice and private hospital care, all of whom shall be doctors of medicine." This amendment would bring the provisions for the personnel make-up of the National Medical Care Council in line with, and parallel to, the provisions for the personnel structure of the National Dental Health Council as described on pages 37 and 38, section 815, paragraph (b).

(4) Paragraph (c), section 101, page 3, reads as follows: "The administrator, who shall engage in no other business, vocation, or employment, shall be a citizen of the United States and a doctor of medicine licensed to practice in one or more of the States and who is outstanding in the field of medicine." We suggest that the language in this paragraph of the bill be amended to read, "The administrator, who shall engage in no other business, vocation, or employment, shall be a citizen of the United States and a doctor of medicine licensed to practice in one or more of the States, with not less than 10 years of experience in the private practice of medicine and who is outstanding in the field of medicine." We suggest this amendment because we feel that it is vitally important for the administrator to have such experience and background as will insure a sympathetic understanding of the problems of private medical practice and private hospital administration.

(5) For very much the same reasons we suggest that the language used in lines 16 and 17, paragraph (c), section 104, page 9, be amended as follows: "at least 10 years of active private medical practice and who is outstanding in the field of medicine."

(6) We also suggest that the language in the second sentence of paragraph (d), section 104, page 10, and which reads, "Such council shall be composed of eight members, at least three of whom shall be doctors of medicine who are specialists in obstetrics or pediatrics" be amended to read, "Such council shall be composed of eight members, not otherwise in the employ of the Federal Government, at least five of whom shall be doctors of medicine who are specialists in obstetrics or pediatrics with not less than 10 years of experience in the active private practice of their medical specialty."

(7) It is also suggested that paragraph (c), section 203, page 13, be amended by insertion after the word "control", in line 7, the following language, "exclusive of clinical treatment." This amendment is suggested as a check on the already strongly developed tendency in the United States Public Health Service to invade the field of the private practice of medicine.

In conclusion, we wish to say that we agree with the statement in the bill that there are some inadequacies in the distribution of health services in our country but we do not agree with those proponents of socialized medicine who continue to assert that these inadequacies can only be corrected by compulsory centralized control. As a matter of fact, we believe these assertions are entirely false. In our opinion the compulsory socialization of medicine would eventually make all health agencies and medical services increasingly inadequate. Therefore we urge the passage of Senate bill 545 as a step forward in the development of a voluntary, noncompulsory national health program that will promote the health of all our people without destroying their sense of self-reliance and responsibility and without depriving them of their liberty.

## APPENDIX I

### OFFICERS OF THE UNITED PUBLIC HEALTH LEAGUE OF AMERICA

Chairman, Dwight H. Murray, M. D., Napa, Calif.
Vice chairman, Lester A. Stevenson, M. D., Salt Lake City, Utah.
Secretary-treasurer, Jesse D. Hamer, M. D., Phoenix, Ariz.
Executive secretary, John Hunton, San Francisco, Calif.

### *Washington Representatives*

James J. Boyle, Ben H. Read, room 410, Hill Building, 17th and I Streets NW., Washington, D. C.

### *Board of Directors*

In addition to the officers listed above, the board of directors is made up of a representative from each State medical association in the league as follows:

Colorado, Bradford Murphey, M. D.
Idaho, vacancy due to death of Parley Nelson, M. D.
Montana, Raymond F. Peterson, M. D.
Nevada, John R. McDaniel, M. D.
Wyoming, W. Andrew Bunten, M. D.

## APPENDIX II

### OFFICERS OF THE COLORADO STATE MEDICAL SOCIETY

President: A. C. Sudan, Kremmling.
President-elect: John S. Bouslog, Denver.
Vice President: Lawrence T. Brown, Denver.
Constitutional secretary (3 years): Bradford Murphey, Denver, 1948.
Treasurer (3 years): William A. Campbell, Colorado Springs, 1947.
Additional trustees (3 years): W. B. Yegge, Denver, 1947; F. A. Humphrey, Fort Collins. 1948; Ervin A. Hinds, Denver, 1949; E. H. Munro, Grand Junction, 1949.

(The above nine officers compose the board of trustees, of which Dr. Murphrey is the 1946–47 chairman.)

Assistant treasurer (1 year): George C. Shivers, Colorado Springs.
Executive secretary: Mr. Harvey T. Sethman, 835 Republic Building, Denver.
Board of councilors (3 years): District No. 1—J. H. Daniel, Sterling, 1948; No. 2—Ella A. Mead, Greeley, 1948; No. 3—L. G. Crosby, Denver, 1948; No. 4—Ralph S. Johnston, La Junta; No. 5—W. K. Hills, Colorado Springs, 1947; No. 6—C. A. Davlin, Alamosa (chairman of board for 1946–47); No. 7—A. L. Burnett, Durango, 1949; No. 8—Lawrence L. Hick, Delta, 1949; No. 9—W. W. Sloan, Hayden, 1949.
Delegates to American Medical Association (2 years): W. T. H. Baker, Pueblo, 1947 (alternate—T. D. Cunningham, Denver, 1947); William H. Halley, Denver 1948 (alternate—Claude D. Bonham, Boulder, 1948).
Foundation advocate: George H. Gillen, Denver.
Delegate to Colorado Interprofessional Council (5 years): K. D. A. Allen, Denver, 1949; (alternate—Carl McLauthlin, Denver, 1949).
General counsel: Messrs. Hutton, McCay, Nordlund and Pierce, attorneys, Denver.

## APPENDIX III

### COLORADO HOSPITAL SERVICE (THE BLUE CROSS PLAN)

Colorado Hospital Service was incorporated on May 26, 1938 under the provisions of the Colorado statutes governing nonprofit corporations. The purpose as stated in its by-laws is to "establish, maintain, and operate a nonprofit hospital service plan whereby hospital care shall be provided to persons who become subscribers to the plan of the corporation under a contract entitling each subscriber to certain hospital care by and at the hospital with which the corporation may from time to time contract." The organization has been continuously approved by the Blue Cross Commission since September 1, 1939.

The board of trustees is organized as a self-perpetuating community body responsible for the administration and functioning of the Colorado Blue Cross Plan, serving without remuneration.

Enrollment in the plan is open to established business groups consisting of two or more persons, and by arrangement with rural organizations. The rates are: Single subscriber—85 cents per month; applicant and first family member—$1.50; and, applicant and two or more family members—$1.90 per month.

In return for these monthly dues, the subscriber and members of his immediate family under the age of 19 receive semiprivate accommodations in any one of 35 member hospitals throughout the State up to 21 days per person the first year, 25 days per person the second year, and 30 days per person the third year.

Since its beginning in 1938, membership has grown steadily. A total estimate compiled as of April 1, 1947, was established at 450,000 men, women, and children who are subscribers in the plan. This represents an enrollment of over 40 percent of the State's 1,100,000 population—300,000 from urban areas; 150,000 from rural areas. The plan is now concentrating on rural enrollment through organized county-wide enrollment programs, granges, co-ops, and other farm groups. The present enrollment is averaging 2,500 new members per week.

## APPENDIX IV

### COLORADO MEDICAL SERVICE, INC.

Colorado Medical Service, Inc., is sponsored by the Colorado State Medical Society and was the outgrowth of several years' study of voluntary prepayment plans by this society. It was incorporated April 19, 1940, under Colorado statutes governing nonprofit corporations. It is managed by a self-perpetuating board of trustees, serving without remuneration and representing the community at large.

Enrollment of subscribers began in May 1942 and at first was limited to the Denver metropolitan area. Early in 1946 the plan had proved its financial soundness and public popularity and then was extended to the entire State of Colorado. At present, more than 1,200 physicians of the estimated 1,550 doctors of medicine in private practice in Colorado have signed agreements as participating physicians. Subscribed membership on April 1, 1947, was 203,637 men, women, and children, and are now increasing at more than 1,500 per week. About 175,000 subscribers are urban; a little less than 30,000 are rural. The plan is now concentrating on obtaining rural subscribers.

Colorado Medical Service currently offers a plan for surgical care. As soon as actuarial studies indicate a sound policy a broader coverage will be offered. The present plan includes complete surgical service by participating physicians to any subscriber whose family income does not exceed $125 per month if an individual, $160 per month if a family of two, or $200 per month if a family of three or more. The doctor is reimbursed under an exact and minimal fee schedule and is obligated to render complete service to such subscribers. He is permitted to charge an additional fee to persons whose income exceeds these levels. Any employed group or approved rural organization may obtain membership. Monthly rates are: Single subscriber, 75 cents; applicant and one dependent, $1.50; applicant and two or more dependents (including all children under 19), $2. In December 1946 the plan began administration of out-patient treatment of service-connected disabilities of veterans under a Veterans' Administration contract.

Senator SMITH. The next witness is Dr. E. F. Sladek, of Traverse City, Mich., chairman of the council, Michigan State Medical Society; secretary, National Conference on Medical Service. Doctor, we will be very glad to hear from you.

Senator MURRAY. Doctor, I am very sorry, but I can't remain to hear your testimony; I have to leave now, but I will read your testimony in the record with great interest. Following the doctor's testimony, Mr. Chairman, I would like to have this put in the record. It is an article that is printed in the Survey Graphic magazine.

## STATEMENT OF DR. E. F. SLADEK, TRAVERSE CITY, MICH., CHAIRMAN OF THE COUNCIL, MICHIGAN STATE MEDICAL SOCIETY, SECRETARY, NATIONAL CONFERENCE ON MEDICAL SERVICE

Senator SMITH. Before you begin, Doctor, will you be goon enough to state a little biography of your background and experience to qualify you as a witness at this hearing?

Dr. SLADEK. I am chairman of the council of the Michigan State Medical Society, having been on the council for 9 years and its chairman for 3. Incidentally, I am secretary of the National Conference on Medical Service.

Senator SMITH. Are you a practicing physician yourself?

Dr. SLADEK. I am a practicing physician.

Senator SMITH. How many years' experience?

Dr. SLADEK. My statement has that; 27 years. It is in the statement.

Senator SMITH. If you think the other qualifications appear in the statement, I will let you go right ahead.

Dr. SLADEK. I believe so.

Senator SMITH. All right, sir.

Dr. SLADEK. I feel that the ideology on which S. 545 is based is sound. That is, it is a good bill. Should this bill become law, the health of our people can be materially benefited. The efficacy of any national medical-care program can be judged only by its value at the local level. I speak from the local level, as I have spent 27 years in the practice of medicine in Traverse City, Mich., which has a population of 15,000 and serves a rural area having an additional 10,000 population. This region is typical of those areas in the United States which are removed from the immediate influence of great urban centers.

1. The advantages of the national-health bill of 1947 are that it continues and encourages voluntary prepaid medical-care plans. In areas such as my 25,000 population county, the operation of a voluntary prepayment medical-care plan has, over the past few years, resulted in the correction of many long-standing disabling defects among the people and has made a major contribution to the health of the entire population. S. 545 favors a continued development and encouragement of such voluntary prepaid medical-care plans. This is a highly desirable feature of any national-health plan, as it permits people having a relatively small income to budget their funds to defray the cost of unforeseeable illnesses, accidents, and surgical repair.

2. The care is adequate under voluntary prepaid medical-care plans. The care given under voluntary prepaid medical-care plans is adequate to meet the needs of the people. In my locality, it has been demonstrated repeatedly that those who carry such protection need not and do not worry about receiving care for any illness which would seriously impair the health of the person or his ability to make a living. I must qualify this by saying that this does not provide for care in extended illnesses such as tuberculosis or infantile paralysis and such disabling diseases. However, those afflicted with such diseases are being cared for under State and National programs of both a governmental and nongovernmental variety. I refer to such programs as the vocational rehabilitation service, the tuberculosis commissions and associations, the National Infantile Paralysis Association, and so forth. Under S. 545, all medical services by governmental agencies will be under one directive head and consequently, because of a more uniform type of service, these patients can be more efficiently covered and served.

This protection provides care for the great majority of cases which physicians on the average meet in their daily practice, and thus the great majority of illnesses confronting the people. These contracts do not provide for preventive medicine. To do so would be unnecessary duplication for preventive medicine from the State level is being taken care of most adequately by the State departments of health, medical societies, various educational organizations and departments. On the local level, preventive medicine is not sufficiently expensive to be of great concern since it consists mainly of inexpensive regular physical check-ups and a knowledge of healthful living. I repeat when the voluntary medical care program can be placed within the reach of all who desire it the health of the people insofar as medical care is concerned will be adequate.

3. It is desirable to the patient. From the standpoint of the patient, the care given under voluntary prepaid medical care plans is the most desirable of any variety. Under these plans the patient-physician relationship is maintained; the facilities of the best institutions are available; the stigma, if such exists, of charity is not present; red tape is cut to an absolute minimum; the care of the patient is given by physicians of the patient's choice; delay in the administering of medical care in emergency cases is unnecessary.

4. It is satisfactory to the doctor. Voluntary prepaid medical care plans are satisfactory from the standpoint of the doctor. It provides him with adequate recompense for his services so that he can locate in any area in which there is adequate demand for a doctor and thus provides a means for the proper and adequate distribution of medical care to all areas. He feels confident in the administration of such plans for representatives of his own profession, elected by him, serve in administrative and in advisory capacities on the governing boards. By daily experience, he is familiar with the procedures, forms, and implementations. He feels he is carrying on the traditions developed under the private practice of medicine which have proved to be most capable of advancing the standards of his profession.

A classic example of how the voluntary prepaid medical care plan can be adopted to care for the medically indigent is supplied by the home-town plan for the care of veterans now being carried on in Michigan under Michigan Medical Service. The type of cooperation which may be expected from doctors under such a plan is evidenced by the fact that while no veteran has been given less than adequate and proper care, nevertheless only 60 percent of the authorizations for care granted by the Veterans' Administration have been used by our Michigan doctors of medicine. Example: a veteran is allowed 10 treatments for his particular illness; the doctor who would have been paid for 10 treatments find the patient needs but 6 treatments to effect a cure; the Government has been spared the cost of the additional 4 treatments. This record indicates that the doctors, far from being greedy, as is occasionally charged, have given veterans the best care they knew, with results beneficial both to the patient and to the Government. That is the kind of cooperation that can be expected from a voluntary medical care program in which the medical profession has confidence.

5. It would enlarge coverage of voluntary medical care plan to include the medically indigent. The value of such plans is not disputed. It is only their limited coverage which seems at fault. S. 545 is a remedial measure which will go far to extend the coverage of these plans so that any person who so desires can receive the benefits. In other words, it will provide coverage for that income group known as the medically indigent, those who can provide themselves and their families with the basic necessities of life, i. e. food, clothing and shelter, but may not be able to protect themselves financially against unpre-

dictable illness. This group represents a good percentage of the people of such an area as Traverse City. By the extension of such coverage as is given by voluntary prepaid medical care plans to the medically indigent, S. 545 will render a second great service.

The service can be all-inclusive. If particular groups are included under the Taft-Ball-Smith-Donnell bill, such as clients of old-age assistance, aid to dependent children, welfare clients and others now being cared for under the Government plans, the voluntary group medical care plans can include them, similar to the manner in which they have accommodated the Veterans' Administration and its great pressing problem: a plan which works equally as well in my community of 25,000 population as in the largest cities of the State.

Senator SMITH. Doctor, I would like to ask you one or two questions. I appreciate your very clear statement. I understood you to say you have lived in Traverse City, Mich., with a population of 15,000, surrounded by a rural area. Do you have the problem in Traverse City of the workers in factories or in industry, or don't you have that problem?

Dr. SLADEK. Mildly so. Some of our rural people are in the indigent class.

Senator SMITH. You are not primarily an industrial city, then, with the problems of a big industrial population?

Dr. SLADEK. No, sir. We have charities.

Senator SMITH. Do you feel that this program that you have described here, your voluntary medical care plan plus the aid to be given by a bill such as S. 545, would give a pretty adequate over-all coverage for the area that you have had experience with?

Dr. SLADEK. That is right.

Senator SMITH. Do you think that would meet practically all of the medical needs that you have?

Dr. SLADEK. I am pretty sure it would, Senator.

Senator SMITH. Now, Doctor, I want to ask you—I have had handed to me to be introduced into the record by Senator Murray after you complete your testimony, an article appearing in the Survey Graphic of May 1947, entitled "The Veteran's Own Doctor," by Mr. William G. Reidy, who has been assisting Senator Murray in some of these hearings. That article criticizes Michigan's treatment of veterans pretty severely. I wonder if you are familiar with that article?

Dr. SLADEK. I am not familiar with the article, Senator.

Senator SMITH. Then you cannot make any statement, so far as the article is concerned. It will appear in the record, and I will be very happy to have a copy of the record sent to you with the article, and if you care to make a comment I will see that it is introduced in the record as your answer to the criticism made here of the veterans' program in that area.

Dr. SLADEK. I will be glad to do that.

Senator SMITH. I do not know that I have any further questions to ask you except this one: You speak of the indigent. Of course, we have the medically indigent and we have the so-called indigent. They are always present. No matter what plan is adopted, whether a policy of insurance or otherwise, we always have a certain percentage of the population that even under a compulsory plan could not contribute to it, because they are indigent and have to be taken care of, and I suppose that any program adopted will have to provide in some way to take care of them, either by charitable organizations or possibly State aid or Federal aid, to take care of that group. You did not include that group in your statement here. You spoke of the "medically indigent." We recognize that class, and S. 545 will take care of them. It would likewise, I think, take care of the completely indigent, because it would include them in any plan under which the Federal Government granted aid to take care of these people.

Dr. SLADEK. The completely indigent, as far as they can be covered by the plan, will be covered through the purchase of policies by the local county welfare agencies as they exist.

Senator SMITH. Do you share the view of many of our other witnesses here that, taken as a whole, the group Blue Cross plan has been very successful and has been growing because it has rendered a service that the public needed?

Dr. SLADEK. That is right.

Senator SMITH. And you think the Blue Cross nonprofit plans are preferable to commercial-insurance plans in the field?

Dr. SLADEK. Very much so. So far as the patients are concerned that I come in contact with, those that have the Blue Cross policy and the others that have the commercial plan, there is much greater satisfaction under the Blue Cross or Blue Shield plan, because the commercial companies are on an indemnity basis, and the patient just gets so much for the health insurance, and in most cases insufficient and not as much as they expected. That is my experience in talking to the patients.

Senator SMITH. Are you familiar with the Blue Cross program just in the State of Michigan or as extended all over the United States? Have you got an opinion on the general spread of it throughout the country?

Dr. SLADEK. Yes; I have an opinion on the general spread. I believe that it is spreading like wildfire, and it is spreading and covering the entire country.

Senator SMITH. And the originators were really doctors themselves?

Dr. SLADEK. That is right.

Senator SMITH. It is their attempt to answer this problem of taking care of our people in the lower-income brackets?

Dr. SLADEK. That is right.

Senator SMITH. Thank you very much, Doctor. We greatly appreciate your testimony.

Dr. SLADEK. May I just give you a piece of information for the record, Senator?

Senator SMITH. Yes, indeed.

Dr. SLADEK. This is relative to the distribution of medical personnel, and it refers particularly to the disappearing rural practitioner. I am pleased to report that the deans of our medical schools fully realize that there is a lack of interest by our medical educators in the general practitioner and in rural medical service. Eighteen or twenty deans of medical schools, in reply to a questionnaire asking for suggestions as to topics for discussion at the 1948 National Conference on Medical Service selected the subject of the training and continued education for general practice, and methods of stimulating interest in rural practices. I think that information would apply to that provision of S. 545 in which there is an interest in attempting to get rural practitioners, or to get doctors for small communities.

Senator SMITH. I might say that our committee as a whole realizes that one of the most important areas to explore is the rural community, where there is not incentive for the doctor; that we want to take that up particularly in our whole program.

Dr. SLADEK. That was my thought in putting this in, inasmuch as the deans are beginning to realize that they have overemphasized specialty training.

Senator SMITH. Of course, you personally will agree that it would be very helpful in the rural problem and this over-all hospital plan if under the bill passed last year we could get the program moving to install hospitals in rural areas, which will be a place where the doctors will logically gravitate if they have the facilities of hospital laboratories and what-not, so that they may have a successful practice.

Dr. SLADEK. Yes, sir; and a good hospital program.

Senator SMITH. That is what we have in mind in developing the over-all hospital program. It is a big subject. It cannot be fully treated in 15 minutes. It is one, as I see it, of evolving from experience. I like your approach very much, and the feeling that the voluntary insurance plan has possibilities of growth and expansion from experience in giving the coverage that we need.

Dr. SLADEK. Yes, sir.

(The article submitted by Senator Murray follows:)

## THE VETERAN'S OWN DOCTOR—HOW HOME TOWN MEDICAL CARE WORKS IN THREE STATES AND WHY THE NEW VA PROGRAM IS A PROVING GROUND FOR ORGANIZED MEDICINE

By William G. Reidy

The Nation has decided that the veteran is entitled to complete medical and hospital care for any ailment caused or aggravated by his military service. It is the job of the Veterans' Administration to see that he gets it promptly and effectively. This was quite a task even in 1945 when the number of veterans was just beginning to climb toward the 20,000,000 mark, and Gen. Omar N. Bradley, VA's distinguished new Administrator, and Gen. Paul Hawley, his medical director, took over. (See "A Better Break for Veterans," by Hillier Kreighbaum, Survey Graphic, January 1946.)

They quickly infused new life and vigor into the VA's 25-year-old hospital and clinic system. Planning 74 new hospitals with 136,000 beds, they determined to add quality to quantity. The new hospitals were scheduled, not for isolated areas like most of the old ones, but in or near centers of population where educational facilities and skilled consultants would be available to the hospitals' salaried doctors. The country's leading medical schools were brought in to raise and maintain standards of care. Consultants were secured. Thousands of young doctors were employed. And in order that these VA physicians might be welcomed to the ranks of organized medicine—as had not been the case—the cooperation of the American Medical Association and of State and county medical societies was enlisted.

The home-town medical care program was one byproduct of that cooperation. No more disarming and bucolic title ever cloaked a revolutionary development.

### COMPLICATED SIMPLICITY

The ex-serviceman can now go for treatment to Dr. Smith or Dr. Jones down the street, instead of traveling to a VA hospital or clinic. These physicians continue to function as private practitioners, paid by the VA on the same fee basis as they would be by you and me. The home-town program is as simple as that. Deceptively so, as we shall see.

The VA wanted the program because it would mean prompt care for ex-servicemen—and for strategic reasons, too. The doctors wanted it because it meant that many veterans would be cared for by private physicians instead of by the VA's salaried doctors. The veteran liked it for obvious reasons.

But the new program would have proved impossible if the VA had had to work out individual agreements with 100,000 or more practicing physicians. State medical societies, acting as agents for their members, seemed the obvious answer. To date, 39 such societies have entered into contracts with the VA, each attempting to solve four basic problems in ways most satisfactory to its members and to the Veterans' Administration. The active cooperation of doctors must be obtained; Federal funds must be proceeded; high standards of care ought to be assured; red tape ought to be minimized.

This is where it begins to be less than simple. When doctors are not paid by the patient but by someone in his behalf, the relationship can no longer go unregulated. There is a vast amount of experience about how to regulate it; but this experience is known to few administrators, very few doctors, and hardly at all to the general public. Public welfare departments cultivate this experience when—as in some States and many cities and counties—they pay doctors and hospitals for furnishing care for their clients. So do some voluntary health insurance plans. So has the Federal Government, notably in its plans for low-income rural families and its war-time program of maternity care for soldiers' wives. Many basic administrative problems are the same whether the money comes from insurance contributions or from tax funds, and whether the administering body is voluntary or public.

The VA program is bigger than any of these. It touches 2,000,000 veterans today. It may touch 20,000,000 within a few years. Whether its inevitable expansion follows the home-town pattern or another perhaps less acceptable to the doctors depends on how well the medical societies succeed in shaping it to satisfy the three chief parties at interest—the veterans, the doctors, and the people who pay the bills. How well it will satisfy them depends in turn largely on the effectiveness and the economy of the administrative patterns devised.

Fortunately those patterns are not yet set in concrete. Different programs are being tried in different States. The time has not yet come for appraisals. It is ripe for exhibits—New Jersey, Michigan, and New York—which will reveal problems and issues on which the future of health insurance and of tax-supported medical service may hang.

### NEW JERSEY

When Joe Veteran in Pinewood, N. J., began to shake with chills and fever last spring he recognized the enemy he first met in the South Pacific. "It's that malaria again!" Luckily Joe's roommate had read something in a newspaper about the Medical Service Administration of New Jersey—"the doctors' prepaid medical care outfit"—having signed a contract with the VA. Slightly disbelieving, Joe hauled himself over to old Dr. Vane, who had been his family doctor for years.

Dr. Vane examined Joe, gave him a treatment, and then together they filled out a not-too-long report, Joe furnishing details of his service record, the doctor stating his findings, and telling how many treatments he thought Joe would need. This Request for Authority for Out-Patient Treatment was mailed to the VA's local regional office.

Joe ought to come back next week, Dr. Vane said, but he should wait until the Medical Service Administration approved and returned the authorization form. An examination and one treatment, said Dr. Vane, was all the VA could agree to pay for sight unseen. Joe went home happy. He waited 1 week, 2 weeks, 3 weeks. The authorization did arrive in the fourth week, but it was already invalid. Authorizations were good for 1 month only! Dr. Vane drew up another request. This time the authorization came through within a fortnight.

The VA had not wasted time. It had to check Joe's eligibility for service just as a medical society would for any member of its own prepayment plan. It had to make sure that Joe's disease was service-connected and that the treatments Dr. Vane proposed to give seemed appropriate in kind and number. The VA did not even wait the 3 to 8 weeks it might have taken to get Joe's service record from the Army. It took a chance on that, since the malaria reported by the doctor seemed clearly service-connected. The VA set up its necessary record and then issued the authorization.

Not to Joe, however. It went to the Medical Service Administration because, under the contract between the New Jersey doctors and the VA, the MSA was to act as a go-between. It was to keep the list of doctors and to pay their bills.

Obviously the MSA, too, would have to record the services authorized and to whom, if it was to send checks to doctors and then seek reimbursement from the Government. So the MSA proceeded to set up much the same records as the VA already had. Only after that was the authorization mailed to Joe.

Dr. Vane's bill also got lost in red tape for a time. It had to clear through both agencies, and the Medical Service Administration would not send the doctor a check until it got the money from the VA.

All this seems a cumbersome, wasteful duplication of effort. It was. The MSA recognized the fact, and at the end of 2 months told New Jersey's doctors that it was serving only as "a fifth wheel and a bottleneck." The doctors promptly decided to turn all the strictly administrative work back to the VA, leaving to the medical profession and its agency its true function of providing medical care.

### NEW JERSEY TRIES AGAIN

Dr. Vane gets paid now in 30 to 45 days. In some parts of New Jersey where the VA's newly decentralized fiscal system is functioning, doctors are being paid in from 2 to 3 weeks. He has not minded the wait too much. Compared to the bills his private patients owe him, he knows that every bill for a veteran's care will be paid in full—and at nice fees. The fee schedule is the same throughout the State, and if the leading doctors in Newark think it is a good one, it certainly is all right for Pinewood.

But paying bills and checking eligibility are not medical care. In reflective moments doctors realize the the VA is obligated to pay only for services which are of acceptable quality and which are actually needed by the veterans. Who should supervise the quality of care? Who should prevent the possible padding of bills? Both initially and, under the current program, the VA and the New Jersey State Medical Society had agreed to delegate these thorny jobs to the doctors themselves. "Controls" by Government would be "regimentation."

The medical society assumed the job. It agreed to—

Certify a list of competent physicians;

Review their work;

Make investigations regarding the adequacy of their reports;

Serve as a liaison between the VA and the doctors.

It has assigned one doctor to do all of these things.

New Jersey's physicians know that only a very few of their number are venal. Hence they evidently find it difficult to face the fact that reviews and sanctions have to be set up for all the doctors in order to control the 4 or 5 percent who might ask authorization for six treatments when four would do, or recommend an unnecessary but lucrative operation, or call in the services of fee-splitting specialists in cases which general practitioners could properly handle. Under any plan, the necessity for treatments given is checked against the initial examination of the patient. In New Jersey the same physician furnishes both. Controls are decidedly necessary.

Established methods of review and control are available to the society should it choose to face the facts inherent in its free choice, fee system plan. They require only a little money but not a little courage. Dr. Vane does not believe the rumor about one doctor having requested authorization for 18 treatments for every one of his VA patients. Not that this doctor's county medical society told a VA representative that it would take action only after the doctor had been proved guilty in a court of law. Dr. Vane may or may not know that last August 19,758 New Jersey veterans received 31,360 treatments under the home-town program, whereas this January—5 months later—19,200 veterans somehow "needed" over 82,000 treatments. Dr. Vane's society should know these things, however. And that in January the sums paid to New Jersey doctors were running at a rate of about $185,000 a month.

Without a medical review of the cases involved these figures do not prove abuse. But they and the nature of the system itself may instill some nervousness into the leaders of a professional association which has accepted the responsibility for self-discipline. The figures should disturb administrators and taxpayers.

### MICHIGAN

In Michigan, the Home Town Program is almost identical in form of contract and in method of operation with the original New Jersey plan. It involves the same duplication of efforts and evinces the same lack of effective controls. There is, however, one big difference in substance. The Medical Service Administration in New Jersey has been a small struggling plan of health insurance under medical society control, whereas the Michigan Medical Service is the largest such plan in the country. It has a highly efficient administrative staff, partly its own, partly in the affiliated Michigan Blue Cross plan. With this staff it could, and did, see to it that the doctors got paid for veterans' care within 3 weeks after their bills came in. The MMS had ample funds to draw upon while it waited for VA reimbursement.

By the same token, the Michigan Medical Service probably would have been the best qualified agent of any State medical society to undertake complete responsibility for operating a Home Town Program. Actually the VA has not delegated nor has the MMS sought such authority and responsibility. The VA merely delegates a part of the job, pays the MMS a 7 percent fee to get it done, and then, in effect, does the same job all over again by itself.

The Michigan Medical Service employs no checks against exploitation save to compare individual bills with their individual authorizations. Nor does it set any standards or enforce controls. It disclaims any responsibility or authority along such lines under its present contract. Interestingly, the MMS has just the International Business Machine set-up needed for statistical control work but has no responsibility for controls. The VA has the responsibility but lacks the machinery.

The one positive function which the Michigan Medical Service seems to render in the Michigan plan is that of paying its own doctors promptly. It charges the Government 7 percent for the privilege.

### DOLLARS AND SENSE?

Michigan and New Jersey contrast sharply in one important respect—the fee levels. In each State, the VA has negotiated rates with the medical society. Michigan doctors with whom I talked seemed generally satisfied with what they were getting. All that is, but one Detroit physician who had been unhappy ever since he had seen New Jersey's fee schedule. And it does seem curious that if the veteran has a hernia repaired, the Government will pay $100 if the surgeon lives in Detroit or Grand Rapids, but $175 if he is from Newark or Cape May. Rates in these States seem usually the same for the services of general practitioners or for work done mainly by laboratory technicians. But of 200 comparable items for the services of surgeons and other specialists, the New Jersey rates run higher in about 60 percent of the items. In almost a third of these, the excess is 50 percent or more.

I do not urge that national uniformity would be desirable. Such a development might well have disastrous effects on many State and local programs as well as on those of other governmental agencies. In fact, conditions in localities within some States vary so much that a uniform State schedule may be a way of making the high fee areas set the level for all areas. In the case of the two States we have specifically studied, Senator Byrd, Congressman Taber, and other citizens will watch with interest whether, as time goes on, VA fees in New Jersey come down or Michigan's go up.

### NEW YORK

New York contrasts with New Jersey and Michigan (and with many other States) in several ways. One difference is at the vital stage of authorization. The veteran in New York can go to any doctor he chooses for treatment, but his first step is to visit a VA examination clinic. There a VA doctor examines him, makes a diagnosis, certifies his eligibility for care, and gives him an authorization for treatment which sets forth, with the diagnosis, the character and extent of the treatment authorized.

The patient is thus saved the long delay between examination and treatment which characterizes the Michigan type, and authorizations can safely run for as long as 3 months. More important, though perhaps not so obvious, it serves the veteran by giving him the only effective guaranty of quality of care we have yet discovered in these programs.

The VA physician knows that his diagnosis will be subjected to automatic review by the physician chosen to treat the patient. Any apparent errors will be quickly called to his attention if the physician asks that the authorization be changed. And it works both ways. The veteran's doctor is put on his mettle too, if that is necessary.

Moreover, this departure provides a positive check against several of the evils previously referred to. With a salaried physician making most of the diagnoses, the economic incentives to exploitation are largely removed. With them disappears the need for many of the controls, the red tape, the investigations which are inherent in any completely free choice, free-for-service program.

The agent of New York's Medical Society is the Veterans' Medical Service Plan of New York, Inc. (VMSP). Five physicians, their salaries paid by the VMSP, are at work. Unlike New Jersey's one doctor, these five men have a definite responsibility. They are located in VA offices in different parts of New York State. While the VA does all the routine administrative work, the VMSP's doctors have direct access to all records and can, efficiently and without duplication, carry out the VMSP's functions of representing the practicing physician before the VA, maintaining the cooperation of doctors, and handling all disciplinary matters.

Dr. Herbert Bauckus, a leading figure in the New York State Medical Society, has called the program "a milestone in the truly American tradition of democracy in medical care." Of VA's vesting disciplinary controls in the society's hands, he remarked, "the freedom of action in this regard is unique in the annals of medicine."

### GOVERNMENT OR MEDICINE?

Home Town Programs need study designed to bring out their positive values as well as such negative ones as we have examined—achievements regarding quality of care, lower costs, and effective administrative procedures as well as devices for avoiding pitfalls. Such studies should be made by the VA itself. The program is big in the number of people and dollars involved, and is pregnant with importance for future medical care in America. It therefore imposes on the VA the responsibility for much more than fumbling, State-by-State "experimentation." Expert, critical, comparable analysis of administrative policies, and methods is an obligation up on the VA as the program moves along. Such studies would be infinitely more constructive than post-mortems by newspaper columnists or by a congressional committee.

Certainly this brief glance at three State programs suggest, too, that organized medicine should be urging and assisting in such analysis; should be eager to adapt programs to their findings. Organized medicine now demands not merely participation in, but complete control of, health insurance plans and tax-supported medical care. Its claims can now be measured against its deeds. Its future status may well depend on this current test of its ability properly to discharge the inescapable responsibilities of power. Can medicine change itself or must Government change medicine? The Home Town Program is a proving ground.

Senator Smith. Thank you very much, Doctor.

We have one more witness this morning, Dr. J. P. Sanders, President of the Louisiana State Medical Society, New Orleans, La. I understand that Dr. Sanders has with him Dr. Guy R. Jones and Dr. W. P. D. Tilly.

## STATEMENT OF DR. J. P. SANDERS, PRESIDENT, LOUISIANA STATE MEDICAL SOCIETY, ACCOMPANIED BY DR. GUY R. JONES AND DR. W. P. D. TILLY

Dr. Sanders. That is right, Senator.

Senator Smith. We will be glad to hear, shall I call it the "triumvirate"?

Dr. Sanders. Yes, sir; the Three Horsemen. Dr. Jones is from Lockport, Dr. Tilly from New Iberia, La., and I am from Shreveport. All three of us are country doctors at heart; all three of us have practiced in the city.

Senator Smith. You are horse-and-buggy doctors that can travel in automobiles? Is that right?

Dr. Sanders. Yes, sir. Dr. Jones happens to be chairman of our rural health committee of the State of Louisiana.

Senator SMITH. I think that for the record you might just put in a very brief biography of each one of the three. You say Dr. Jones is chairman of the rural health program?

Dr. SANDERS. Of the rural health committee of the State of Louisiana, the Rural Health Service of the State of Louisiana.

Senator SMITH. And Dr. Tilly?

Dr. SANDERS. Dr. Tilly is one of the vice presidents of the State Medical Society of Louisiana. We are all engaged in general practice in the State.

Dr. TILLY. In our health program we have memorial hospitals and small hospitals. I have been a horse-and-buggy doctor and member of the International College of Surgeons. My father was a French physician and practiced in the horse-and-buggy days, so I have had two generations of doctors back of me.

Senator SMITH. Quite a medical atmosphere.

Now, Dr. Sanders, you have been too modest. Will you state your own qualifications?

Dr. SANDERS. Just a country doctor moving to town, Senator. That is all. I have been in Shreveport 5½ years. I practiced out in the country out of Shreveport about 20 miles for 14 years on the plantations. I used to brag about the fact that Caddo Parish had seven white families.

Senator SMITH. You represent the Louisiana State Medical Society?

Dr. SANDERS. Yes, we are representatives of the Louisiana State Medical Society.

Senator SMITH. Are you officers of that society?

Dr. SANDERS. Dr. Jones is the counsellor from the third district, which is one of the executive offices. I am vice president of the house of delegates. That is one of the executive offices. And Dr. Tilly is a retiring third vice president.

Senator SMITH. But you are the present president of the Louisiana Medical Society?

Dr. SANDERS. No, I am vice president of the house of delegates.

Dr. JONES. He is chairman of this committee here, Senator.

Senator SMITH. Very well.

Dr. SANDERS. This brief was prepared by this committee here and was presented before the executive committee of the State society, which is the representative of the State of Louisiana—I mean the medical society of the State of Louisiana.

Senator SMITH. Does your statement indicate what the membership of the State medical society is, the total number of doctors? Do you practically represent all the doctors in the State?

Dr. SANDERS. That is right.

Senator SMITH. And the views you express here, this statement, has been approved by the State medical society?

Dr. SANDERS. Yes, sir; and is their answer to this bill.

Senator SMITH. Thank you very much, Doctor. Proceed with your statement.

Dr. SANDERS. This statement expresses our stand toward the present legislation, S. 545.

Senator bill 454 concentrates all the health activities of the Federal Government under one head. We believe that this is an important change, because it coordinates all the activities and prevents duplication of efforts. It will produce economy in the long run and will be responsible for the activities in one department. We believe that health is so important that the administrator should be on a cabinet level.

We thoroughly agree that the administrator should be a native-born citizen of the United States, who is a practitioner of allopathic medicine, with an experience of at least 5 years' practice in a rural community or town of 5,000 or less. We believe that a general practitioner gets closer to his patients than the specialist and, consequently, would have a greater understanding of the needs of the people. We believe that the Surgeon General of the Public Health Service, the directors of the medical- and hospital-care services, maternal and child-welfare services should also be similarly qualified. We strongly recommend that the medical-care service be kept in the hands of the local communities to be served. The communities, including their doctors, know the communities' needs. Many of them are working on these needs and with a little help, properly placed, can solve their own problems better than they can be solved by anyone else in the world. In the event of disagreement between the local community and State agency, a direct appeal can be made by the community to the administrator.

*Louisiana's contribution to medical care.*--This brief on Senate bill 545, the national health bill, is presented for the Louisiana State Medical Society, representing a total membership of 1,659 doctors out of a total of 2,507 registered in the State of Louisiana. We are responsible for the medical care of the people of the State of Louisiana which has a population of around 2½ million people.

Louisiana has contributed to a large extent to the present status of the high standard of medical practice in the United States. It is the home of two great medical schools, Tulane University Medical School and Louisiana State University Medical School. These two schools have trained some of the great medical men of our time. Louisiana has a total of 167 hospitals, both general and special, with a bed capacity of 9,227. That does not include hospitals for mental patients and for our epileptics, which is about a similar number of beds.

Our State medical society was organized 67 years ago and has constantly stood for the highest type of medical practice. Through its medical schools, hospitals, medical conventions, and societies, Louisiana has tried to train its doctors on the highest plane possible. Through these same organizations we have tried to keep our skirts clear of many of the isms that have crept into other States. As time has progressed we have tried to improve accordingly. We have cooperated with the Government and other lay groups in keeping the practice of medicine free. We believe that patients get better treatment under the American plan of the present doctor-patient relationship than under any other system in the world. We are willing to vary that plan by the trial-and-error method whenever it seems feasible to do so.

Louisiana is attempting to give good medical care to all its people. Economically, people fall in three general classes so far as medical care is concerned: the well-to-do or rich, the marginal group, and the indigent.

Senator SMITH. Would you say, Doctor, that the second group there is what we would call medically indigent?

Dr. Sanders. That is the general group that we are talking about. You mean the second, marginal group?

Senator Smith. The marginal group. We have been discussing here in many of these hearings so-called medically indigent. That is people who can take care of themselves but cannot take care of their medical expenses.

Dr. Sanders. The medically indigent are taken care of, and I will explain later on in the discussion of this paragraph, and if I have not then answered your question, I will be glad to do so.

Senator Smith. I wanted to bring out whether you meant the medically indigent by this "marginal group."

Dr. Sanders. We are speaking purely, of course, of medicine here, to a large extent of the medical condition. Of course, they are mixed up so much with financial conditions that it is hard to separate them.

(Senator Ellender took a seat at the committee table.)

Senator Smith. I am glad Senator Ellender has come in to hear his distinguished constituents from Louisiana. I am sure he will be glad to hear from you gentlemen. You probably know him.

Dr. Sanders. Senator, I am just about half through with this statement.

Senator Ellender. I am sorry I did not come in earlier.

Dr. Sanders. The first group of people, the well-to-do or rich, are financially able to take care of themselves and, therefore, need no help or guidance.

The third group, the indigent, is very well taken care of in Louisiana through our system of charity hospitals, charity clinics, department of public welfare, and many other social agencies. Louisiana has 7 charity hospitals with a bed capacity of 4,808 for care of indigent alone. There are additional beds for indigents in private hospitals throughout the State. Our total hospital capacity in Louisiana is 9,227. Over half of the general beds in Louisiana are for indigents alone. The charity hospitals are startegically situated in different portions of the State. They are in close enough proximity that most any indigent person can be carried there in a short period of time. No pay patient can go into our charity hospitals or such institutions. No one can go there except the indigent. These hospitals are well equipped with X-ray laboratory, clinical and pathological laboratories, physiotherapy department, nursing schools, graduate nurses and technicians, and a well-trained medical staff that can take care of any of their medical needs.

The second group, the marginal group, is the one about which we are greatly concerned. We must remember that many of our great leaders have come and are coming from this marginal group. In our eagerness to help them solve their problems we should not deprive them of the initiative that may later make them leaders in industry, the professions, or in politics. I might divert there to say that I myself am a product of that marginal group. We must give such help in such a way that it will stimulate their initiatives but will not hamper their progress. The marginal group to a large extent covers four classes of people:

Most all farmers, particularly the small operators.

Large families who have moderate incomes.

Small families with moderate incomes who have unusual responsibilities for some reason or other.

Those with definite low incomes because of their own inefficiency or otherwise.

Most individuals in this group are very independent. They want the better things of life but they want to pay for them. They detest charity. The farmers in particular are the most independent people in the world and that largely is the reason they are farmers even in spite of their low income.

The rural-health committee has told us repeatedly that they do not want any charity whatsoever.

The farmers are developing cooperatives, both producers and consumers, in order to help themselves. These include medical services in many instances. Hospitalization insurance, particularly the Blue Cross plan, is well developed in Louisiana. The low-income groups are particularly interested in this type of insurance to take care of those catastrophic illnesses which all too often ruin the marginal family.

The Louisiana State Medical Society has been working on a prepayment medical service for 3 years and was able to start issuing policies in November 1946. The Louisiana Physicians Service is the insurance company organized and operated by the Louisiana State Medical Society. To date—7 months—over 15,000 policies have been sold in groups alone. The policy is planned to take care of catastrophic illnesses such as surgery, obstetrics, and X-ray examinations. Those are types of illness of course, that will ruin the marginal group. Of course, they can take care of a house call, or even a short spell of illness, but a long illness will ruin them. Over 75 percent of all the doctors in Louisiana have already agreed to take care of the marginal group for the nominal fee provided in this policy. The people are cooperating in this prepayment medical plan. It is the American way of solving an American problem.

Senator ELLENDER. Right there, Doctor, how does this plan differ from the so-called Blue Cross plan?

Dr. SANDERS. Senator, we have a number of Blue Crosses. I think that will be brought out by one or two of the others later. This is the Blue Shield. Our company is the Blue Shield. But we have a combination of Blue Cross and other groups in Louisiana. The different cities that are organized now are making an effort to organize on a State-wide basis.

Senator ELLENDER. What I had in mind was, is this organization to which you refer in any way affiliated with any of the larger organizations doing the same work?

Dr. SANDERS. We are a member of the independent organization on medical care.

Dr. JONES. This is organized by the Louisiana State Medical Society. We put up the money for it.

Dr. SANDERS. But we are a member of the national organization of similar type, Senator.

Senator SMITH. You mean the National Blue Cross and Blue Shield?

Dr. TILLY. The Blue Shield, not the Blue Cross. The Blue Shield represents medicine and the Blue Cross represents hospitalization.

Senator SMITH. We have had testimony here that in Massachusetts they have the Blue Shield as well as the Blue Cross.

Dr. Tilly. Yes, we have the same thing in Louisiana.

Senator Smith. I take it yours is the same.

Dr. Tilly. But we are two independent sections. The Blue Cross, which is hospitalization, is one; the Blue Shield represents medicine in our organization, but the money comes from the State of Louisiana Medical Society. We are cooperating together, the Blue Shield and the Blue Cross, working hand in hand.

Senator Ellender. But the Plans are about the same?

Dr. Jones. They are identical, both nonprofit.

Senator Ellender. What about the fees charged? Are they about the same?

Dr. Tilly. They are about the same.

Senator Ellender. Will you give what the cost is in your statement?

Dr. Sanders. The cost, Senator—suppose you have a wife and 10 children, or 14 children, the top fee on that is $2.10 per month.

Senator Ellender. For the whole family?

Dr. Sanders Yes.

Senator Ellender. Is that Blue Shield or Blue Cross?

Dr. Sanders. That is Blue Shield. The Blue Cross, I cannot give that right off-hand, because it is not a part of our organization, the Blue Shield, for the catastrophic types of illness. You understand we are going along slowly here to start with. We don't want to make some of the mistakes that some of the others have made and go broke before we get started.

The Louisiana State Medical Society has a very active committee on rural medical service. It is composed of five physicians located in different portions of the State. At our State convention held in New Orleans 4 weeks ago this committee was given broad powers to cooperate with the Farm Bureau, Rural Hospital Service, and other interested groups to improve rural medical care in the State of Louisiana. We are encouraging general practitioners to settle in rural areas. We are working with the State Hospital Council in locating rural hospitals at strategic areas in the rural communities as provided for under the Hill-Burton bill. The Rural Health Committee of Louisiana is anxious to see rural people obtain just as adequate medical care as the people of urban areas.

Medical care is expensive. The cost of good medical care has become expensive, not because the doctors want it but because the patient demands it. The patient is not satisfied to go into a doctor's office for him to take his blood pressure, temperature, look at his throat, listen to his heart, and write one or two prescriptions, and let him go. The average patient would say that this is poor medical care. The average patient who now goes to a doctor for a complete check-up requires:

1. A complete medical history.
2. A complete physical examination.
3. Laboratory examinations, whenever necessary, of the blood, urine, stool, secretions of the body, blood chemistry, and many special examinations that may be required.
4. An X-ray examination of any or all parts of the body that might be involved.
5. Heart tracings are frequently demanded by patients that have high blood pressure or heart disease.

6. Special eye, ear, nose, throat, kidney, stomach, rectal, and other examinations may be required.

All of this means that the patient has increased the expense of his examination enormously from that which was required 50 years ago. First of all, the physician has to have a well-equipped X-ray and clinical laboratory with trained technicians and nurses to operate them. More space is required and more clerical help is necessary. The treatment of the patient's condition may not be so expensive after he has been diagnosed. However, many cases may require infusions, transfusions, plasma, and other expensive drugs not formerly known, such as penicillin, streptomycin, and so forth.

We might as well try to get our patients to go back to the horse-and-buggy days for their transportation as to take them back for cheap medical care. The horse and buggy cost approximately $200, the old model T Ford could be bought for around $600, while the present automobile will cost around $1,500. People in the marginal group, however, require an automobile in which to ride in spite of the cost, and also they want modern medical care regardless of the increased cost. None are willing to go back to the horse-and-buggy days.

Senator ELLENDER. Why is it that patients require all these things? What has caused this change?

Dr. SANDERS. The patients, Senator, are not ignorant any more. Our lay journals, our newspapers, have been so full of medical topics for the past 25 years that the people are acquainted with those things. They know something about those things. Frequently a patient comes in and suggests to me, "Don't you think I ought to have some penicillin? Don't you think I ought to have sulfa drugs?" They know about heart cases, they know about blood counts, they know about urinalysis, they know about X-rays. Frequently a patient comes in and——

Senator ELLENDER. Tells you what to do?

Dr. SANDERS. With a specimen of urine, and says, "I want a urinalysis," or "I want a blood count."

Dr. TILLY. I have run a clinic all my life, both in the city and in the country, and I have been a country doctor previous to the clinic days, and the people demand all these things constantly, all classes, blood examinations, heart examinations, urinalysis, and so on. The public has been educated, educated by the lay papers.

Senator ELLENDER. And some of the older doctors who do not keep up with the times might be embarrassed sometimes?

Dr. TILLY. Yes, they might.

Senator SMITH. How long would it take, for example, to make these six examinations?

Dr. SANDERS. Senator, if you were asking for a complete examination, which I judge you are referring to, if you came into my office or Dr. Jones' office or Dr. Tilly's office, and said: "Doctor, I want a complete going over," we wouldn't just paint your throat and let you go, and I don't think you could get out in less than 3 or 4 hours.

Senator SMITH. What I was going to say, I have been out here at Bethesda hospital for a check-up, and certainly it took the better part of the day.

Dr. SANDERS. Of course, when you add to that the specialist's examination, you could not do that in 3 or 4 hours. As we have said here, if you took a thousand patients and spent 2 or 3 hours at a time on each one, you could spend your whole life on it. It depends on the help you have and how many technicians and nurses and so forth. I practiced medicine down in the country without any help at all. I practiced down there without even a colored girl to help. Our cook ordinarily cleaned up the office, and so forth. Now my son and I have six girls. I don't need to tell you that I charge more. I have to charge more than I did years ago in the country.

Senator SMITH. Does your Blue Shield plan enable the doctors to give that complete coverage?

Dr. SANDERS. Yes, that has been the plan, but we have to sort of lay up a backlog. We have got to get some insurance experience in this type of thing.

Senator SMITH. I was going to say, have we had experience enough yet to know what a load of that kind would mean on the insurance?

Dr. SANDERS. We think we know approximately, but we are not sure of it yet. And of course, it has to be properly controlled. Any time you go to giving people something for what they think is nothing, of course, they are going to ask for it. There is no question about it, we have got to watch that in the medical field in the treatment of medicine. Of course, as long as you keep in surgery and obstetrics and X-rays and so forth—of course, a woman is not going to have a baby every 9 months, but she must be taken care of when she does—a man is not going to have his appendix taken out twice in 1 year; he is not going to have a hernia repaired twice unless necessary. So we are going slowly along with this thing by the trial and error method—which is, of course, the logical way of doing it.

Senator SMITH. One thing that has been brought out by the witnesses here is that if we have the over-all tax that the Murray bill calls for, compulsory tax on pay roll for the payment of that tax the worker expects to get over-all coverage——

Dr. SANDERS. Yes, sir.

Senator SMITH. If every worker came in and called for it, he would have a right to have an over-all check-up?

Dr. SANDERS. Yes, sir.

Senator SMITH. It might not be possible for some time to so organize the profession as to meet the commitments made by the Government because of that fact. That is what troubles me about the compulsory tax.

Dr. SANDERS. After practicing medicine for 20 years you learn a lot about people besides the treatment of diseases. If a patient comes in and says: "I want you to just give me the works, all the X-rays, all the heart examinations, all the laboratory tests," that is going to run into money, but in any sort of over-all coverage you are going to have that type of thing if it is not watched. And in the insurance policies, as you will notice, we specify certain things to do. And the doctors have to be honest about those things.

Senator ELLENDER. Dr. Sanders, for such an examination as you have just read there, consisting of six different items, doesn't that run into some kind of specialized medicine that the average country doctor would not be equipped to do?

Dr. SANDERS. Not necessarily, Senator.

Senator ELLENDER. Wouldn't it cost a lot to make such a series of examinations?

Dr. **Sanders.** Yes, that is what I say. I say all of this means that the patient has increased the expense of the examination that he formerly got.

Senator **Ellender.** Then you would be somewhat curtailed in the number of patients you could treat?

Dr. **Sanders.** Unless you have other technical help.

Dr. **Jones.** That is what I was about to say. The Senator asked a question as to how much time would be consumed for one of these examinations, and the answer was approximately 3 or 4 hours, but that would mean only the time that the patient will be taking, the time of the patient himself. It does not mean the interpretation of all of these laboratory findings. The doctor would have to do that himself, which would take more of the doctor's time. For instance, we have technicians to do the laboratory work, take X-rays, run urine and blood analyses, and all that, but then the interpretation comes to the doctor himself, who is qualified to interpret those different findings. The technician does not make interpretations, so that requires more time on the part of the doctor in the examination, which is not stated in the time consumed by the patient himself in the doctor's office.

Senator **Smith.** You say more time will be required rather than less. There will be 3 or 4 hours for the examinations, and then there is additional time required by the doctor?

Dr. **Sanders.** Yes; just in keeping with what Dr. Jones has said. I had a patient from Texas last week who stayed there a whole week for her examination. That doesn't mean I was taking up all of my time in the examinations. As a matter of fact, most of my time was not taken up with her, but we did X-rays of the gall bladder, which required 2 days, gastric examination, arterial, urine, blood, Shirley-Collins test, a KGS on her, and X-rays of chest. All those things required—I think she was there a week and 1 day to finish up all the examinations. Of course, that did not require all of the doctor's time, but it required the time of the girls and the technicians. She came there for all those examinations. She knew I would do it, which was the reason she came. She came 250 miles, but she would not have come if she had not wanted that service. Patients come into your office asking for those things, and the point we are making in this brief is that medical care has gotten expensive because the patients want it.

Dr. **Tilly.** As a country doctor with 15 years' experience in industrial areas, sawmills, salt mines, and the like that we have, in my early years they were all under the contract system. These patients did not use the doctor very much, and they only called the doctor during a period of illness, but since those days, the horse-and-buggy days, times have changed, and I have run diagnostic clinics most of my time in late years. The diagnostic clinic means time, and I bought an electric clock for a history chart which was to take 15 minutes. I had to break the clock, because they didn't finish telling their history within the 15 minutes. The complete examination of a clinic report, and most of them desire that now—or a part of the clinic report—means hours for the staff to do, even 20 or 24 or 48 hours for a complete report. In the larger clinics, like Mayo's, you go in and stay a whole week to get a complete statement of where you stand. After the complete examination you pay as much as you are able to pay for the damage to nature that has taken place in that group of patients. In the horse-and-buggy days on the sugar plantation the patient would telephone: "Doctor, I am having a baby," or "Doctor, I have malaria." They made the diagnosis themselves, and it was just a matter of coming in and going out. Those days are passed—gone, and they require more service and more time. That is what we are bringing out now, that times have changed. You don't stay in a home more than 15 to 30 minutes on an ordinary call, and the ordinary doctor usually says: "Let me see your tongue," and then he feels your pulse, and then the prescription will be written. That is the way it used to be, but that is not the practice in medicine today. It would be sad for any of you to have that if you had something serious.

Senator SMITH. Thank you very much, Doctor. Now, Dr. Sanders, will you continue with your statement?

Dr. SANDERS. Medical practice in this country has progressed to the present high standard under the American plan. Whenever any attempt is made to regiment medical practice it deteriorates. These are our recommendations:

1. That the administrator should be a native-born citizen of the United States, who is a practitioner of allopathic medicine with an experience of at least 5 years' practice in a rural community or town of 5,000 or less.

2. That the qualifications for the Surgeon General of the Public Health Service, the directors of the Medical and Hospital Care Services, Maternal and Child Welfare Services should be the same as those of the administrator.

3. That any appropriation under this bill be a grant-in-aid on a community level.

In conclusion, we recognize Senate bill 545, with alterations as suggested in this brief, to be the most favorable bill presently offered for the American people and the medical profession.

Senator SMITH. What do you mean, Doctor, by "community level"? The philosophy of the bill is to financially aid the States to work out their own programs on the State level, community level, and so on. You don't want the Federal Government to move into the community and try to determine the program of the community?

Dr. SANDERS. We want the community to determine its own needs, Senator.

Senator SMITH. That would be done through the State society?

Dr. SANDERS. That is right.

Senator SMITH. And your State would get, under the bill, a certain portion of the appropriation for the needs of Louisiana, we will say, and then your local crowd through your State medical set-up will determine the community needs?

Dr. SANDERS. Quite right. And that can be handled by local people. We don't want a bill that will get it into politics in our State. We want to keep it out of politics.

Senator SMITH. I think we all feel that very strongly.

Dr. SANDERS. We have seen the cancer problem worked out; we have seen poliomyelitis worked out. We have seen tuberculosis in the hands of lay people and physicians, and it has worked out beautifully. In the time that I have been in medicine tuberculosis has dropped from first, the top of the list, down to eighth in the short period of a few years. And there hasn't been any State control.

I was very much amused to hear just last week the report that we got of the Shreveport Tuberculosis League, of which I am a member. Our secretary reported that she had on her committee 200 women in the city of Shreveport working on the Christmas seal campaign, and that they had on their subcommittees over 1,000 women working in the city of Shreveport for no pay, for one project, one division, one purpose, and I could not help but remark in the board meeting that that was the American way of solving an American problem.

Senator SMITH. Thank you, Doctor.

Senator JONES. You asked one question there about aid being on a community level, that Dr. Sanders explained. He stated that although this is going to be under State administration the way it is proposed by this bill, the community should have the right in case of question to override the State and appeal directly to the National headquarters for aid where the aid will not be granted by the State.

Dr. SANDERS. That is what I tried to emphasize.

Dr. JONES. That is what he tried to emphasize.

Senator SMITH. You mean that will be something to be added to our present bill?

Dr. SANDERS. Yes. And we have certain recommendations for the record, Senator, that we are going to submit.

Senator SMITH. It will be admitted.

I appreciate very much your testimony, gentlemen, your being here with us. You have made a very valuable contribution in the picture you have given us of the Louisiana situation. I congratulate you on the presentation, Senator Ellender.

Senator ELLENDER. We have been working on that problem for quite some time, Senator.

Senator SMITH. I know you have.

Senator ELLENDER. That is why I am so much interested in maintaining it and trying to get it spread over the country if we can.

Dr. SANDERS. There is one other observation I want to make—and this is not for the Louisiana State Medical Association; this is purely Dr. Sanders—I regret very much that Senator Murray could not stay here, but I want to suggest, for my own personal thinking, that he try out his bill—I am very well acquainted with S. 1320—that he try it out in Montana before he impresses it on a national level.

Senator SMITH. I have said right along that I would welcome some experiment, a guinea pig experiment, by some States if they want to try it. I don't want to see it in my own State because I am afraid of it. And so far as supporting a program on a national level, a program of compulsory medical insurance, that has not been thoroughly tested in any one area. Frankly it does not strike me as sound.

Dr. JONES. Senator, I would like to say on the question you asked previously on this bill S. 1320——

Senator SMITH. That is Senator Murray's bill.

Dr. JONES. Yes. As to page 38, you specifically stated as to what this agency, the board, was composed of, and you specifically stated "Social Security" here. I think that if there ever has been, in my personal opinion, an unpopular bill for the layman it is that Social Security bill. They don't like to have deductions from their take-home pay. They want it all, and they want to be able to say what they are going to do with it themselves, and so far as I can see, as an employer myself who has to pay part of the Social Security along with the employee, who has to pay his part, it is, in my estimation, one of the most unpopular things the country has, and if you are going to add medicine to this, it is going to be a calamity, not just unpopular.

Senator SMITH. I appreciate your comment. That, of course, is the general program of S. 1320, to put the program under the Social Security umbrella, you might say.

Dr. JONES. And you are going to bring us doctors directly back to the horse-and-buggy days, because we won't have the initiative to work to produce the goods for our patients. We will have no compensation ahead, as far as Sanders and myself are concerned. We have been practicing medicine for 20-some-odd years, and we think we have reached our peak in the medical profession. You may say: "Doctor, you will be put on a salary. You won't have anything to worry about. You will have a good living. Your family will be well taken care of." That is fine for us, but how about the patients we are going to treat? We won't have that incentive to go out and give the patients the best we have, because, to begin with, we admit we haven't got enough doctors, and the burden that will be thrown on the doctors that already exist will be so far-reaching that we will not be able to give them the examinations that they require. If we attempted to give that examination, we would be able to give it only to a very few, and the vast majority would be without any examination at all, and you are just going to make matters worse as you go along. Then the incentive for young men to study medicine will drop. Personally, I believe the Senator has a son and I think a brother and a few nephews that are doctors.

Senator SMITH. I believe he has 10 children. Didn't they say you had 10 children, Senator?

Senator ELLENDER. No; not me.

Dr. JONES. But I daresay that if his son could have foreseen the medical profession being regimented, he would have preferred probably being a lawyer or something else rather than a doctor, because they pretty much have their say-so on things—or he might even be a farmer, because they lead a happy life, happier than to be regimented—although the farmers are sort of being regimented themselves, from what I can see, and we don't want a socialistic form of government here. We want an American Government, the Government that we have been fostering since this country was developed, and we want to keep it on that basis if we can. And the doctors are fighting for just that one thing.

Dr. TILLY. Let me say in addition to that, as to my staff in my hospital and clinics, I am paying the Social Security myself and not charging it to anybody else. I tried to make doctors out of my two sons and I have made dentists out of them, because they thought socialized medicine was coming to such an extent that they would be slaves, so they are dentists instead of doctors. And that is the third generation.

Dr. SANDERS. Senator, I believe that if Social Security in our section—I know in my own office—if it were put on a voluntary basis rather than compulsory, it would be a flop. I am sure about that. I can't speak for any other section.

Senator SMITH. You mean if it was put on a compulsory basis?

Dr. SANDERS. No; if it was put on a voluntary basis instead of compulsory, it would be—the people wouldn't have it.

Now, I don't feel that I am capable of discussing this thing, but Senator Murray made a very important statement, it seems to me, a while ago, and I was hoping that we could ask him what he meant by it, when he said that our economy is collective, that we have a collective economy in the United States. Well, maybe I don't know what an economy is, but of course we are accused of being Russian and we have been accused of being socialistic, like the Germans and like the Italians and some of the others, but if we have collective economy in the United States it certainly is not as apparent in the South as it is here.

Senator SMITH. I think Senator Murray was referring to the industrial development of the country, the over-all large industries. I don't agree with his conclusions, but I think that is his opinion.

Dr. JONES. But he wants to put the medical profession in the same category.

Senator SMITH. Yes; I think his idea is that because we move in that direction, we have to deal with our health problems on the same wholesale basis.

Dr. JONES. He has already said we could not recede from that, but if we ever get into social medicine we will never be able to recede from it again, and we are going to take it away from State administration.

There is one thing in this bill, since we are discussing it, he says here on page 39, line 22: "All functions of the board shall be administered by the board under the direct supervision of the Federal Security Administration."

If I remember the Federal Security Administration correctly, out in our section it was a complete flop, and it is going to get floppier if you put the medical profession under it.

Senator SMITH. Then the conclusion to be drawn from your statement is that you do not want to see the health business of the United States placed under the Federal Security Administration?

Dr. JONES. Absolutely not. I am stating my personal opinion, not that of the Louisiana State Medical Association.

Dr. SANDERS. We don't want any medical OPA.

(Dr. Sanders submitted the following proposed amendments to S. 545:)

### SUGGESTED CHANGES IN READING OF SENATE BILL 545

1. Page 3, section 101 (c), line 13, add "native born" before "citizen."
2. Page 3, section 101 (c), line 14, add "practicing his profession and who has practiced in a rural community or town of 5,000 or less for 5 years or more" and "who is" before the word "licensed."
3. Page 9, section 104 (c), line 14, add "native born citizen" before "a doctor."
4. Page 9, section 104 (c), line 16, add "in a rural community or town of 5,000 or less" before "and who is."
5. Page 10, section 104 (d), line 3, change the word "three" to "five."
6. Page 10, section 104 (d), line 4, add "two general practitioners and three" before the words "who are."
7. Page 14, title VII, part A, section 702 (a) (1), line 15, add "composed of four laymen and four practitioners of medicine" before "as the sole."
8. Page 14, title VII, part A, section 702 (a) (2), line 23, add "composed of four laymen and four practitioners of medicine" after "council."
9. Page 16, section 703 (b), line 15, add "after 2 years" after "repaid."
10. Page 17, section 712 (a) (1), line 7, add "composed of four laymen and four practitioners of medicine" before "as the sole."

11. Page 17, section 712 (a) (2), line 14, for the word "include" substitute "consist of."
12. Page 18, section 712 (a) (3), line 1, delete "public and."
13. Page 18, section 712 (4) (b), line 13, add "agency" after "State."
14. Page 18, section 712 (4) (b), line 20, add "agency" after "State."
15. Page 22, section 714 (a) , line 19, add "agency" after "State.".
16. Page 22, section 714 (a), line 21, delete "governmental."
17. Page 22, section 714 (a), lines 24–25, delete "governmental."
18. Page 24, section 715 (b), line 25, add "in active practice and who have had an experience of 5 years or more in a rural community or town of 5,000 or less" after "doctors of medicine."

Senator SMITH. Thank you very much, gentlemen, for your testimony.

Dr. SANDERS. May I give this one joke before we close. Everybody north of Alexandria, La., is called "damned Yankee."

Dr. TILLY. "Damned Yankee doctor."

Senator SMITH. Some of us "damned Yankees" have made some very dear friends among some of you fellows, one of them my good friend Ellender here.

Senator ELLENDER. It is mutual.

Senator SMITH. Before closing this hearing I want to read into the record a letter I have gotten from Helen Gahagan Douglas, a Representative in Congress from the Fourteenth District of California, with regard to the testimony before this committee, and I want to make a brief comment on it. Mrs. Douglas writes me as follows under date of June 6, 1947:

> DEAR SENATOR SMITH: Enclosed is my statement with regard to the legislative proposals embodied in the National Health Insurance Bill, S. 1320, and the Taft Bill, S. 545.
>
> Since I cannot be present to testify personally, I shall be most appreciative if my statement is read into the testimony.
>
> Thank you for this courtesy.
>
> With all good wishes.
>
> Sincerely yours,
>
> HELEN GAHAGAN DOUGLAS.

I want those present to hear Mrs. Douglas' comments here, and my own comments on her statement, which is as follows:

STATEMENT TO MEMBERS OF THE SUBCOMMITTEE ON HEALTH OF THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE BY REPRESENTATIVE HELEN GAHAGAN DOUGLAS, FOURTEENTH DISTRICT OF CALIFORNIA, FRIDAY, JUNE 6, 1947

Mr. Chairman, I understand that this committee has requested and heard testimony from California on the legislative proposals embodied in the Taft bill, S. 545, and the national health insurance bill, S. 1320, supported by President Truman.

I feel that it is most appropriate that the subcommittee should consider testimony from the State of California—should consider both the experience that has been had there and the views that are reflected as a result of that experience. I think it most inappropriate, however, for the subcommittee to have limited testimony from California to a few spokesmen who speak not for the people of my State but for those groups and those forces that over the years have persisted in blocking the enactment of a real health program in the State of California and who now seek to defeat a national health insurance program by giving support to a "substitute" charity measure.

In California, perhaps to a greater extent than in any other State, the people have had opportunity to experiment with a wide variety of different types of voluntary health insurance plans. As a result, the people have in recent years vigorously supported proposals for the establishment of a State-wide compulsory insurance plan. The Governor of our great State, Governor Earl Warren, following in the footsteps of his Democratic predecessor, has reflected in his own position on this question the wishes of the people of our State. Yet I note that

> neither organizations representing the people of California nor the legislators who respond to the people of California nor the Governor of California have been asked to appear here. Instead your committee has invited only those who represent groups that have opposed the people and opposed the Governor in the effort to get better medical care for all of the people at a price they can afford.
>
> One illustration—it is significant I think that those invited to appear here represent forces in California that attempt to foist upon the people a compulsory scheme of their own. I am referring to the California Medical Association bill recently voted upon favorably by the assembly committee on public health of which Assemblyman Geddes is a member and a bill which I have no doubt is being pushed vigorously by the United Public Health League.
>
> That bill would deny workers free choice of insurance plan and free choice of physician. Unless they undergo considerable red tape workers would be compelled to accept a plan and a decision made on behalf of their employers. This kind of a proposal coming from such quarters as it does is as typical as it is indefensible.
>
> Surely it is most undemocratic for decisions of that kind to be made on behalf of the people and it would be equally undemocratic for the Congress of the United States to make a decision on behalf of the American people considering fully and without reflecting the views and the opinions of the American people.

That is the end of her statement, and I want to make this comment. I regret very much indeed that Mrs. Douglas did not consult with me before sending this statement, which I understand she has released to the press, and which implies that there has been some unfairness in conducting these hearings.

I recall that I called it to Mrs. Douglas' attention, and I want it to appear in the record that it was distinctly understood by the committee that we would begin hearings on S. 545; that the proponents of S. 545 would be heard first, and we have allotted time for the opponents of S. 545 to appear after that. We granted time to Senator Murray for S. 1320. I want it further to appear in the record that S. 1320 is a successor and modified bill of the Murray-Wagner-Dingell bill, on which 31 days of testimony was taken in the last session, which testimony will be considered by this committee in considering S. 1320, and we have asked Senator Murray to present two or three days of testimony—whatever he wants—in explaining the differences between S. 1320 and the Murray-Wagner-Dingell bill of last year.

We did not feel it was necessary to invite opponents of S. 545 at this stage of the game from any of these States. We have asked people who believe in S. 545 to be heard, and heard as proponents of the bill.

When we have our hearings of those opposed to S. 545, California or any other State can send whatever witnesses they want. I told Senator Knowland this morning that this matter was coming up, and I said I would be more than happy to have Governor Warren come here and testify. We want all the light we can get on all these suggestions. There has been no attempt in any way, shape, or manner to cut off anybody from testifying here; but of course, being limited as to time, in any orderly procedure first you have the proponents, then the opponents, and then you have, as in this case, opportunity for those who sponsor a separate bill, which at the moment is not before the committee, to state their case. As I have stated, I think that is the fairest way, the fairest possible way to do this, and I think the suggestion that this committee has been unfair in its way of conducting the hearings on the bill, and giving out press releases to that effect without even having conferred with the chairman of the committee, is very questionable ethics.

Senator **Ellender.** The pressure coming especially from opponents of the bill.

Senator **Smith.** I might say in regard to the hearings, we have had 10 hearings in favor of S. 545. There will be six hearings against S. 545. That is all that has been asked for, so far as I know. And there will be three hearings for S. 1320, which I think is all that was asked for S. 1320, which was satisfactory to Senator Murray, to point out the differences between S. 1320 and the Murray-Wagner-Dingell bill of last year, on which, as has already been stated, there were 31 days of hearings in the last session of Congress.

If there is no further business to come before the committee, the meeting will stand in recess until June 25, because this subcommittee had another matter to take up next week.

Dr. **Jones.** I want to openly express my gratitude to Senator Ellender for coming to the hearing and helping us out.

Senator **Smith.** And I want it to appear in the record that I am very appreciative of Senator Ellender appearing at the hearing to meet and greet his colleagues from the State of Louisiana.

(Drs. Jones, Sanders, and Tilly submitted the following material:)

### *What about our death rate during the war?*

Even with a shortage of physicians and nurses, death rates remained surprisingly low and in many areas even decreased.

The Statistical Bulletin of the Metropolitan Life Insurance Co. pointed out in January 1946, that the health of the American people, as reflected by the death rate, was maintained at a very high level in 1945, as it was throughout the war period. The death rate for 1945 was 7.4 per 1,000 or 2.2 percent below a comparable figure for 1944.

The same bulletin showed that mortality from conditions associated with child bearing declined 12.2 percent from that of 1944. For the chronic degenerative diseases the 1945 record was also favorable. The number of cases of poliomyelitis was 30 percent less than in the year before.

* * * * * * *

### *Is the life of the American people increasing?*

Definitely increasing. There are many indications of this. The Metropolitan Life Insurance Co. points out that, in 1944, the average length of life of the American people exceeded 65 years, almost 16 years longer than at the beginning of the century.

According to the Metropolitan's Statistical Bulletin for August 1946, the expectation of life at birth in 1889 was 34 years. In other words, children born today can be expected to live more than half again as long as their ancestors born 50 years ago. Would it not seem that, among other things, we must be getting a higher quality of medical care?

This improvement includes persons in the early years of life and the higher ages as well. The improvement in mortality for a number of childhood diseases has been outstanding. Death from measles and scarlet fever is now comparatively rare, while whooping cough and diphtheria, according to the Metropolitan figures, each registered death rates of less than 1 per 100,000 insured. The mortality from the four diseases as a group is now the lowest on record.

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### *Then what conclusions can we draw from the fact that we are getting such high quality medical care?*

Let's try to be logical. We know that our private medical system is giving us a constantly higher quality of medical care. We know that we have less sickness than countries with public medical systems. Then it wouldn't be common sense to scrap our private medical system in favor of another plan. All we really want to do, then, is to find a better means of paying for the kind of medical care we already have.

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*Is it that average medical bills are too much for the middle class?*

No. On the average the family medical bill is much smaller than quite a number of other family costs: food, housing, clothing, automobile, and entertainment, for example.

The Council on Medical Services of the American Medical Association estimates that in 1942 the per capita cost of medical care (exclusive of dental care) was $23.50. A Gallup poll in May 1946, set the average exepnditure at $50 per year per family. (See p. .22)

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*Are you certain that socialized medicine would have this result?*

It did in Great Britain. Dr. Guy Dain, chairman of the British Medical Association Executive Council, says that officialdom's idea of a good doctor is "the one who gives the least trouble, who always plays safe, and makes no disagreeable fight on behalf of his patients against the State."

*If the doctor is conscientious, he will still work for the patient's interest won't he?*

If the doctor is conscientious, he won't have time to work in the patient's interests. The English doctor, for example, has to master an ordinary office manual of 328 pages of government regulations on how he will practice and what he can and can't do for the patient. There is also, in Britain, a 1,281-page book of statutory rules and decisions regarding compulsory sickness insurance. There will be the inevitable government forms in triplicate the doctor must always make out to prove his claim for payment. A doctor, waist deep in such red tape, hasn't time to give good service to his patients.

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*How much of a mountain of red tape will sickness insurance create?*

Nobody knows. Evidently nobody in Washington now knows the extent of the red tape, directives and regulations which is required to operate the part of the economic system the Government has already taken over.

Said the New York Times in its issue of August 27, 1946:

"Even the bureaucrats, according to the Prentice-Hall news letter What's Happening in Washington, had no idea how big Government has become until they tried to comply with the recent McCarran-Walter Act. This requires all rules, regulations, directives, delegations of authority, organization descriptions and other data to be published in the Federal Register of September 11. This one day's issue would require 6,000 pages; at $60 a page, the cost would be $360,000. A printing of 70,000 copies would take 10 carloads or 600,000 pounds of paper; each copy would weigh 24 pounds and be 18 inches high (as compared with Webster's Unabridged Dictionary, which weighs only 17 pounds and is only 12 inches high).

"The law requires the Federal Register after September 11 to give all new and changed references, directives, and organization set-ups. The result promises to be a daily publication topping the Congressional Record in size. The Government Printing Office, according to the news letter, says it can do the whole job only by suspending the Congressional Record and discontinuing all other Government work. Otherwise a new plant must be set up, 350 new employees hired and $5,000,000 more a year provided.

"The administration is said to contemplate asking the repeal of the new law. But perhaps a better solution would be to control fewer things and to issue fewer regulations and directives."

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*Does not the British panel system allow patients their choice of doctors?*

Free choice of physician was found to be unworkable in Great Britain. People shopped around from doctor to doctor demanding treatments they did not need.

Now British patients can change their doctors only by giving notice and going through specified formalities.

*In general, what has happened to medical care in Britain under socialized medicine?*

Mr. Ernest Bevin has characterized the medical service given British industrial workers as "a tragedy of incompetence." J. G. Crownhart reported to the Wisconsin Medical Society that the English sickness insurance system has reduced many doctors in that country to the status of agents making out prescriptions "too often for mere palliatives." He went on to say that doctors in Great Britain now operate more like "a sickness licensing and registration system than a health service."

*But doesn't the British panel doctor take a personal interest in his patients?*

The better panel doctors are so rushed with work that they simply haven't the time to take a sufficient personal interest in each patient. According to This Panel Business (pp. 340–341): "A high speed has to be kept up to get the work done at all, and to keep the patients leaving as quickly as the new arrivals gather."

*If tax-supported medical care will overcrowd the doctors and result in inferior medical service, why not turn out more doctors than we now have?*

This cannot be done without relaxing the educational standards for those who are admitted to medical schools and are graduated from them. We would have to accept a lower quality of candidate, reduce the educational processes in medical schools, and make doctors out of inferior human material. So again, we come back to this conclusion: Public medicine is bound to be inferior medicine.

*But do the British people get more medical treatment than they did before the day of sickness insurance?*

They do not get more medical treatment but they do get more medicine. With patients swarming into doctors' offices, physicians have to give them something. Sir Kingsley Wood, Minister of Health, recently admitted that the British national sickness insurance system has made the English into "a nation of medicine drinkers."

*Then the British at least get more medicine, if not more medical care?*

In quantity, yes. But the costs of the British system have run up so that the Minister of Health has had to economize. He got the English druggists to make out a list of cheap drugs. The insurance committees which administer the medical benefits have tried to force the doctors to use the list instead of prescribing more expensive drugs.

We had the same experience with the Emergency Relief Administration in this country. Doctors were forbidden to prescribe certain remedies because they were expensive.

*How did compulsory insurance work out in Germany?*

Before the war, Dr. Frederick Hoffman reported that in Germany "treatment of serious afflictions is often grossly inadequate for the purposes of a cure." But the doctors are not to blame. German doctors were paid on a fee-for-service basis. So the administrators were constantly watching physicians for fear they would "overdoctor" patients in order to collect extra fees. On the other hand, many doctors were swamped with patients demanding all the "free" service they could get. Some German physicians estimated that two-thirds of their time had been taken up with people not really needing medical care.

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*Is it likely that the cost will stay within its sponsors' estimate?*

The question is answered by Elizabeth W. Wilson (formerly in the office of the actuary, Social Security Board) in Barron's, April 8, 1946: "It appears probable that health insurance would cost more than 8 percent—some say 10 percent—of the pay roll of insured workers during the next 10 or 15 years. That would be a load of 7 billion dollars by 1960. This estimate is reinforced by the 300 percent rise in per capita costs of health insurance in Germany from 1914 to 1929, and the 250 percent increase in Britain in the same period. Worse yet, actuaries estimate that the increase in costs won't flatten out for 50 years."

*Why have the costs of foreign systems risen so?*

For two reasons: First, because the people begin to demand so much more service when they think they are not paying for it; and, second, because anything done by a government tends to run high in overhead. In Germany, for example, in 1935 there were 36,000 clerks and other administrators overseeing the work of 30,000 doctors. Is there any wonder that the costs run up?

*Private enterprise keeps its costs under control; why can't the Government?*

Private enterprise, including Blue Cross and voluntary medical care insurance, has to operate efficiently, because it has no public treasury into which to dip to make up deficits. Voluntary medical care insurance, for example, has to be so set up that a check and double check are constantly operating on what particular phases of the plan are running in the red. When such an organization starts to lose money, it can be kept solvent either by increasing the premium or decreasing the benefits. Government insurance, on the contrary, does not have to be a financial success. So there is no such opportunity for knowing where the losses are or what the total deficits are to be until they are too large for any course excent to dip into the General Treasury, or drastically curtail the services rendered.

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*Can the average worker afford the cost?*

Even if we assume that the costs of Government medicine will not rise (which they will), and that the rest of the crade-to-grave security program will not be adopted, the cost to the average workman will be terrific. In the first place, remember that the worker is already paying a percentage of all over his exemption as his income withholding tax. Then, too, the old-age pension eventually is going to take 3 percent from him and 3 percent from his employer. And, in most instances, his employer is also paying 3 percent for his unemployment insurance. Of course, whatever his employer pays to the Government means just that much less, in the long run, that can be paid to the worker. Can the worker afford another 3 percent medical deduction on top of this? If you are a worker, do you want to turn such a large part of your income each week to the Government? Counting out union dues, costs of getting to and from work, work clothes, and luncheons, would there be much sense in your earning that extra money? What would happen to ambition and individual initiative under such a system?

*Will the average worker be getting his money's worth from such a system?*

Disregarding quality of medical care, will the quantity be worth the price you'll have to pay? Three percent a year, if you are making $3,600, will be $108 a year. Between 20 and age 60 you will pour $4,320 into the Government system. If anyone spends that amount in an average lifetime for medical care, for himself and family, there must be a chronic invalid among them. But you must also remember that that sum isn't going to buy all the medical and dental care you will need. You may also have to pay for the first medical call in each illness (and quite often you have the doctor but once).

If there are several employed persons in the family, each one pays the tax.

*Would Government medicine affect our basic philosophy of Government?*

Yes. There is a fundamental question involved other than the comparative efficiency of Government and private medicine. In the United States, we regard the Government as an institution run for the benefit of the citizens. In Germany and Japan before the war, and in Russia today, the citizens are regarded as existing for the sake of the government. If we are to keep our philosophy, rather than turn to the German-Japanese-Russian philosophy, we must see that we, the citizens, stay strong enough to run the Government. We must never allow the Government to become strong enough to control us. And yet, during and as a result of the war, the Government has become very strong. Today we have more than 5,000,000 people on the public pay roll, 2,000,000 of them are Federal employees. Add 125,000 physician workers and perhaps 1,000,000 clerks and administrators, to top of the present Government pay roll, and how could we ever overthrow one party in power and put in another? We would find overselves in the control of a perpetuating government, a dictatorship. In other words, the more things the people learn to expect from the Government, the greater the risk the people will succumb to Government control.

*But does not centralization of Government create efficiency?*

No. Senator Robert A. Taft provided the answer in his speech at Syracuse, N. Y.:

"Our experience is that any attempt to regulate the affairs of all the people, of the average citizen in 48 States, is usually both tyrannical and inefficient. Conditions in various sections of the country are completely different. No man, certainly no Federal bureaucrat, knows enough to draw regulations which fit all those conditions. If they fit the part of the country he does know, they are likely to be awkward or nonsensical in other areas. Furthermore, the average man has no voice in the operation of a Washington bureau. In his own city council or statehouse, he can make himself heard. But in Washington he can't even find the bureau or the man supposed to handle his problems. One of the principal services which Congressmen perform is to save their constituents 2 or 3 days tramping through marble corridors. Then when the man is located, the citizen from Syracuse, N. Y., is not likely to get any serious consideration for his problem. Washington is confident of its own superiority, and its general attitude is that the public is 'too damned dumb' to understand. Administration by States and local government is generally democratic. Administration by Washington boards and bureaus is tyrannical."

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### *I. Introduction—the social-welfare philosophy*

The social-welfare philosophy or doctrine proposes that the State should control and direct more and more of the production and distribution of goods and services. In effect, this doctrine denies the integrity of the individual and places the responsibility for guiding the affairs of the individual on the State. The State can only force or coerce individual action to a fixed pattern which eliminates the opportunity for creative action and individual responsibility.

Rules and regulations established and enforced by the State should be designed to place responsibility properly, not take over the operation of our economy.

Compulsory sickness insurance schemes—such as envisaged in the Wagner-Murray-Dingell bill—have developed under this social-welfare philosophy.

The State gets bigger and bigger. The individual, smaller and smaller.

### *II. The political advantage of offering compulsory sickness insurance*

The political advantage of offering the people medical care under a national compulsory sickness-insurance program is an important factor in understanding why such systems have been established in many countries. This advantage of appearing to provide a service so essential and of immeasurable value sets up a great temptation for political or commercial exploitation, or for professional "do-gooders" who have nothing (themselves) to offer except a desire to assist people who, for various reasons, have been unable to maintain a reasonable standard of living. If the politicians and social-welfare proponents can, by law, control and distribute medical care under a national system, requiring only a small direct contribution from the individual, the majority of the people accept it as a benefit from the Government and the social welfare proponents who administer the system.

### *III. It is destructive*

*A. It is not a national "health," but a national "sickness" program.*—It puts a premium on sickness; penalizes the well, the healthy, those who keep themselves in good physical condition.

It pays off on sickness—not health.

Don't fool yourself that you can legislate people into good health. No compulsion, short of sickness or pain, or fear of these, will force the average person to a doctor.

People will get sick so long as they avoid doing anything to keep well.

To retain health is a job for each individual, to keep clean, well nourished, clothed, and housed and understand preventive measures.

A nation of sick people with all the free medical care in the world is nothing as compared with a nation of healthy people who strive to keep well. To regain health is important, but to retain health is far more important.

*B. It will destroy initiative and, therefore, standards of medical practice.*—Political control as envisaged by the Wagner-Murray-Dingell bill will in time destroy the present high standards of medical practice in the United States just as it has done in most European countries.

There was a time not long past when Europe was the mecca for medical education. Today no one can deny that this has been transferred to America. It has been transferred because of the individual initiative of individual doctors, because they have surpassed anything that Europe can produce.

Such legislation will destroy our present standards because the initiative of the individual doctor will no longer be present. Initiative is dependent on two things, desire to get ahead and desire to do a job well. These two things under the present system are dependent on the excellence of the service rendered to patients. Under compulsory sickness insurance they would be dependent on political influence.

It will destroy our present standards because the doctor would no longer feel his responsibility toward his patient. Under compuulsory health insurance the doctors would necessarily be responsible to the edicts of Government officials. The types of treatment, the medicines, the millions of personal things in medical care, would be embodied in these edicts.

*C. It will destroy the private practice of medicine.*—Let's not kid ourselves about this statement. While the Wagner-Murray-Dingell bill provides that the Surgeon General may do this or that, and proponents continue to say he will do only the right things, he can, if he wishes, dictate how, when, and where a doctor can practice medicine.

All the talk about how a doctor can retain his private practice or participate if he wishes is bologna. With 90 percent of the people paying into the scheme, the doctor will have little left for private practice.

Let's look at a statement of the International Labor Office made in 1942. That Office, in a 1942 report summarizing world trends, states:

"The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice, on the one hand, and most of the medical care hitherto given by the public-assistance authorities, on the other. The next step to a single national medical service is a short one. * * *"

*D. It will destroy "free choice of physician."*—It is quite obvious that with little or no private practice there will be no free choice of physician. The patients will be on a panel and when panels of favorite doctors are full the patients will take whom they can get or will be assigned to a panel by a politician.

Anyone with a memory and vision can see himself lining up just as he did during rationing, hoping the political officeholder will grant his request for an extra call this month or will approve a specialist for the baby who is seriously ill.

As for a specialist, the Surgeon General, or whoever administers the program, via the local politico medic in charge, decides who is or who isn't a specialist.

One of the patient's greatest protections under the present system is "free choice." If the doctor doesn't live up to expectations, if he is incompetent in his work or negligent in the care, the patient can select another. This is not so under compulsory sickness insurance.

### *IV. It is not constructive*

*A. It does not promote good medical care.*—Mass treatment of patients can only result in more drugs and remedies and less physician's care.

Political responsibility rather than patient responsibility would by necessity (human nature) result in—

(a) An unequal burden of care falling to the conscientious doctor.

(b) Superficial treatment by the overburdened doctor to get through each day—and by the slacker because he just didn't care and because the Government would provide his panel with patients.

The 8-hour day would be a logical resultant. With this would come less and less research and study.

Fewer good men would enter medicine and more and more would come the medical tradesmen to replace the physician.

It is often contended that sickness is greater in the low-income classes and that sickness insurance will assist this group to remain well. Anyone familiar with the indigent-care programs throughout the Nation knows that the availability of medical service per se has no connection with a reduction in illness.

*B. It does not promote preventive medicine.*—Contrary to the common belief, free medical facilities do not per se mean that the people generally will utilize them for preventive care.

There are hundreds of instances where physicians have cooperated in providing such diagnostic facilities, for prenatal cases, for children, for tuberculosis, cancer, etc. Any medical practitioner will testify to the intense educational campaign necessary to get the people to use the facilities.

Compulsory sickness insurance attacks the problem from the wrong end. The aim should not be so much to provide better care for more sickness but rather to turn attention to the subject of health itself and best methods of keeping it. Let's not confuse sickness and healh. Proponents of compulsory sickness insurance wish to pay people for being sick and penalize them for keeping well.

Practically every argument for compulsory sickness insurance starts with a claim for its superior preventive qualities. This has never been substantiated by comparisons of the United States with comparable countries.

*B.* (*Examples.*)—1. Diptheria: The trend of diphtheria mortality offers an excellent test of the efficiency of medical service. It is one of the few diseases for which treatment and prevention are almost complete and specific.

It is interesting to note, then, that in Germany and England from 1920 to 1927, two countries with compulsory sickness-insurance programs, the mortality rates per 100,000 population were reduced only 13 percent (from 13.1 to 11.4) and 50.3 percent (from 15.1 to 7.5), respectively. While during a similar period the United States reduced its rate by 84.3 percent (from 15.3 to 2.4).

In Sweden and New Zealand, two countries hardly comparable to the United States, yet not having a compulsory program at the time, the reduction was 96.7 percent and 83.8 percent, respectively.

Another good example is well illustrated by the experience under the Rhode Island compulsory monopolistic plan. The incidence of compensated illnesses during 1945 were highest in the month of May. The payments for that month were 169 percent of payments for the month of January. Under voluntary insurance, companies generally agree that the incidence of real illnesses are heaviest during the months of January, February, and March. In Rhode Island the payments for May, June, and July were 57 percent greater than those for the months of January, February, and March. A well-known authority on the subject makes the following comment: "The correlation between the high point in sick benefit payments and the best vacation weather can scarcely be pure coincidence."

*B.* 2.—Tuberculosis is also a preventable disease. Yet in 1934 the tuberculosis mortality rate per 100,000 population in various countries was, New Zealand, 42; Australia, 43.5; United States, 56.6; Germany, 71.9; England and Wales, 76.3; Sweden, 103; France, 126.2.

Many of our States, which would be more comparable to New Zealand and Australia as to population, had rates ranging from 40 down to 20 per 100,000 population.

3. To cite a few of the problems:

Dr. Lowell S. Goin, one of the Nation's outstanding radiologists, sums up the problems, as follows:

"How shall heart disease (except that due to rheumatic fever) be prevented? What sort of health examination will be efficient in its control? How is cancer prevented? Why will the availability of a panel practitioner (who, in any case, will not have time to have her undress) persuade a woman with a lump in her breast to seek advice? (The commonly given reason that she did not see the doctor is that she knew it wasn't cancer because it didn't hurt; never have I encountered such a patient who said she didn't go to the doctor because she couldn't afford it.) How shall we prevent, or even recognize, early brain tumors? Shall everyone with a headache have ventriculographic or encephalographic studies? Shall we do gastrointestinal X-ray examinations of everyone with indigestion? And, if so, where shall we obtain the skilled personnel? How are bone tumors prevented, and what health examination makes one aware of the pneumonia of next week?"

*C. Compulsory sickness insurance does not add anything to medical science nor create healthful living conditions.*—It can only spread the costs of medical care among all the people regardless of the efforts of various individuals to avoid such costs through proper care and living conditions. Lack of sanitary facilities, poor housing, improper diet, and improper personal care are all important factors in maintaining health and avoiding illnesses. Compulsory health insurance will tend to decrease in many individuals interest and responsibility for their own welfare, and penalizes those individuals who do take such interest and responsibility.

Individual responsibility for one's own welfare is not opposed to the common good, and there must be individual interest and responsibility for one's own health before there can be community interest and responsibility for improved health.

*D. It will not redistribute physicians.*—One of the most amazing instances of the conflict between reality and illusion is the assumption that the inequities in the distribution of physicians will be corrected by the compulsory health insurance. There seems to be a vague and hopeful feeling that some magic inherent in this so-called social legislation will persuade doctors to leave cities, where medical schools and libraries are located; where hospitals and consultants can be found; and most of all, where a man can have the society of his peers, and go to remote hamlets where none of these things are available and where he can stagnate in intellectual loneliness. Doctors, like other people, locate themselves where they think they are most likely to succeed and where they will be happiest. Why anyone should believe that enactment of a law will change these elementals is something of a mystery, but one which would be solved promptly if a paternal government were to direct physicians in choosing their fields of activity. Any such intent would be vigorously denied, of course, but the Government of Great Britain has already assumed this right and has announced that more medical care in rural areas would be provided by paying a somewhat larger capitation fee in such areas and (n. b.) by forbidding doctors to locate in more populous zones.

### *V. It encourages sickness, false or otherwise*

*A. The desire to get something in return.*—Compulsion to contribute increases a person's desire to get something in return. This, plus the opportunity to get away from a monotonous job, tends to encourage unwarranted claims for sickness benefits.

Malingerers and neurotics would demand service all out of proportion to their needs. Instead of helping—a "free" service would aggravate such cases.

Excess demand would result in less service to the really seriously ill patients.

*B. Examples.*—A good example of the desire to get something in return is the present unemployment benefit program. Hundreds of thousands of jobs open—hundreds of thousands of able-bodied people loafing around enjoying a vacation on unemployment money.

In a report of a study made by A. M. Simons and Nathan Sinai, called The Way of Health Insurance, the University of Chicago Press, 1932, Chicago, the following statement is made:

"Contrary to all predictions, the most startling fact about the vital statistics of insurance companies is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance."

### *VI. It will not decrease the number of man-days lost from production*

*A. The President's contention.*—On November 19, 1945, the President of the United States in his message to Congress, pointed out that in every year four or five hundred million workdays are lost because of illness or accident, and that about nine-tenths of this loss is due to illness and accident not covered by workmen's compensation law. But he failed to state how many accidents would be prevented by compulsory health insurance. He says that more than one-half of the disabled workers have already been disabled for 6 months, that many will continue to be disabled for years, and some for the remainder of their lives.

Not knowing where such figures came from it is hardly fair to dispute them. One can wonder though how it is linked logically with compulsory health insurance.

Will health insurance end automobile accidents? Does it have the mysterious faculty of causing union in a compound fracture of the femur which, under our present system, will not unite? Will it repair the several tracts of the spinal cord, and prevent the organization of the clot in the subdural hemorrhage?

It would be both interesting and informative to know what part of the four or five million workdays were lost because of that great enemy of man, the common cold, and to know whether the proponents of national sickness insurance have in mind a means of finally overcoming this disease. One thing is certain: the common cold cannot be cured by legislation; the only way it can be prevented is by personal attention to one's own activities, food, and dress.

*B. Analysis of President's contention.*—Reports published by the Bureau of Labor Statistics of the United States Department of Labor and those of the National Safety Council do not support the contention that nine-tenths of the man-days lost are due to illness not covered by workmen's compensation.

In analyzing the 450,000,000 figure it is found that there are direct and indirect losses from occupational injuries which account for 275,000,000 man-days lost. Add to this the 120,000,000 man-days lost because of off-the-job accidents and there is only 55,000,000 left. Not 90 percent but 11 percent of the total man-days lost from work is due to illnesses not covered.

And, too, the Bureau of Labor Statistics indicates that there are two classes of absentees—the voluntary and the involuntary. The former include opening ball games, the fishing or hunting seasons, a hang-over, etc. So the 55,000,000 may be reduced to an even lower figure.

*C. Examples.*—Further, to take a specific example, a study made in 1942 among workers in commercial shipbuilding companies failed to show that illness was a major cause of absenteeism.

A detailed analysis of one of these companies showed that reported illness accounted for only three-tenths of 1 percent of the total absenteeism.

A recent study in one of the largest factories in Connecticut showed that during winter months 50 percent of the absenteeism was due to upper respiratory infections—and during the summer months it remained at about 35 percent. No cure or preventative for the common cold has been discovered and legislation won't prevent it.

Britain's sickness insurance system shows that the average days lost by sickness in the insured population increased steadily and rapidly during the firt years of insurance and never have declined since. European workers lost from 50 to 100 percent more days per year than the residents of this country.

All of this propaganda about saving the poor, ill worker makes one wonder about the loss of man-days through strikes and lockouts.

During the 15-year period, 1930–44, the yearly average was 13,204,826 man-days lost. And in January 1946, a monthly record of 19,200,000 man-days lost due to strikes was established.

It is not only futile; it is a little wicked to draw unwarranted inferences which seem to brighten the rather dull world of reality; to promise that which cannot be performed; and to arouse false hopes in the unfortunate. The social reformer might well learn at least one lesson from the physician, i. e., not to confuse reality and wishful thinking.

### *VII. An analysis of disabilities due to illness*

*A. The statement that there are 7,000,000 disabled persons on any one day due to illness or injury is used to create the impression that all these people are sick and require medical care, and that with a compulsory sickness insurance system this number would be reduced.*—This statement of 7,000,000 persons disabled due to sickness or injury seems to be based on the figures in the National Health Survey conducted by the United States Public Health Service. The data on illness and physical impairments was obtained from some member of the family, usually the housewife, during the 6–month period, October 1935 to March 1936. The survey covered 740,000 urban, and 3,600 rural families.

The original estimate, based on this data, was 6,000,000 people disabled by sickness or injury on any one day. The increase to 7,000,000 may be an estimate based on the increase in population or it may be the usual blow up these people give to such statistics. In any event, the figure is entirely misleading.

*B. 3,000,000 of the 7,000,000 are estimated to have permanent impairments. Compulsory sickness insurance would not provide any benefits for these existing conditions.*—In discussing the number of people disabled in any one day due to sickness or impairments relative to need for medical care, it would be more honest to indicate the true need for these 3,000,000 physically handicapped persons.

As indicated in the National Health Survey report, all physically handicapped persons are included in the total. The number of physically handicapped persons was estimated to be 2,500,000 persons. If we use the 7,000,000 figure, then the maximum number of physically handicapped persons would be closer to 3,000,000. This figure agrees with a report entitled, "Use of Handicapped Workers in War Industry," published in the Monthly Labor Review, September 1943. This report deals with the subject of placing disabled workers in gainful occupations, and stated that progress was being made in the years covered, 1940–43, in accomplishing this objective.

No mention is made in this report of a lack of medical care for the physically handicapped persons. The problems which they emphasized were training these people for jobs and placing them in gainful occupations.

*C. A large proportion of the remaining 4,000,000 disabled persons are the results of accidents. A more reasonable number of people disabled due to illness on any one day would be 2,000,000.*—According to the National Safety Council, were 9,800,000 disabling injuries in 1944. Of this total, motor-vehicle accidents accounted for 850,000; public non-motor-vehicle accidents, 1,800,000; and home accidents, 4,800,000. Occupational injuries and injuries to military personnel accounted for the others. There is no accurate information on the duration of disability from these injuries, but it can be readily seen that accidental injury is an important cause of disability, and to a great extent accounts for the large number of people disabled on any one day. Neither medical care nor the cost of medical care has any influence on the number of accidental injuries.

### *VIII. An analysis of the 5,000,000 rejections under Selective Service*

The following analysis of the rejections under Selective Service was presented by Dr. Lowell S. Goin of Los Angeles, Calif., at the time president of the California Medical Association, in an address at the annual meeting, May 6–7, 1945:

"Since the 5 million 4–F's are so frequently invoked, and since it is at first glance so shocking a figure, let us examine it in some detail. One difficulty with the argument is that intellectually it is not very honest. In Senator Pepper's interim report the figure is announced on page 1 not as 5 million, but as 4½ million, but on page 3 of the same report the graph discloses the true figure to be 4,217,000. An error of 13½ percent can scarcely be considered insignficant. Of the total number rejected 444,800 were rejected as manifestly disqualified, that is to say the totally blind, the totally deaf, the deaf mutes, the legless, the armless, and so forth. It seems perfectly obvious that no program of medical care could have influenced this figure. 701,700 were rejected for mental disease. Again I don't know of a program of medical care which would have prevented mental disease in these unfortunate people; 582,100 were rejected for mental deficiency, that is to say that they were the imbeciles, the idiots, and the morons. The most casual knowledge of eugenics would persuade anyone that this group does not constitute a medical problem, and these three groups together reach the large total of 1,727,600. When these have been excluded there remain 2,426,500. or somewhat less than half of the originally claimed 5 million. Of this group 320,000 were rejected for muscular-skeletal defects, that is to say the clubfoot, the paralytic, the withered arm, the congenitally dislocated hip, and so forth. Again I wonder what program of medical care might have made this group fit for military service. 280,000 were rejected for syphilis. The statute books are already loaded with laws regarding syphilis. There is probably not a community in the United States in which a person afflicted with this disease cannot secure treatment from the Department of Public Health. How, then, would compulsory health insurance have eliminated this group? 220,000 were rejected for hernia. Hernia is a congenital defect and if a person is born with a defective inguinal or femoral canal he is likely to have a hernia, and medical care has nothing whatever to do with the occurrence of hernia; 160,000 were rejected for the 'eyes.' Since eyes would seem to be useful adjuncts to men who were to be soldiers or sailors I presume that this means defective vision.

If one is born with an eyeball too long or too short or one which is not a globe one will either wear glasses or not see very well and medical care has nothing whatever to do with it. Thus about 1 million more have been eliminated and the number of rejections on a basis of lack of medical care would have materially reduced this number is problematical. If the proponents wish to rest their case upon the need shown here (and they have made a great deal of it), I am content."

### *IX. The cost of compulsory sickness insurance*

*A. Costs, apparent and real in Government insurance.*—In this country, as well as in most other countries, the funds for Government social insurance are obtained through a tax on the individual income, a tax on the employer based on wages and salaries paid, and a transfer of money from the general funds of the Government, which are obtained through various direct and indirect taxes.

To the individual worker, the tax on the employer is considered as a gift or bonus, and this is a dominating factor in the minds of many workers and union leaders, since it appears that the worker is getting something extra from his employer. Actually the tax is an increase in wages, and is passed on to the consumer as part of the labor costs of production. The amount of money that is or may be required from the general tax fund is usually not referred to at all or is given very little consideration.

The method of financing Government insurance carefully avoids real cost accounting since the proponents of such insurance realize that if the true costs to each individual were stated, these proposals would meet much greater opposition.

*B. Political disadvantage of true costs.*—If the actual cost is proposed as a direct charge to the people, it would be impossible to obtain support for the system. Political expediency requires inadequate taxes, and once the system is established the lay administrators charged with protecting the funds of the system will continually extend their control of the medical care provided in an attempt to reach an equilibrium between income and expenditures. New Zealand, which started its compulsory sickness insurance program in 1938, has, according to recent reports, found the costs for 1944–45 to be four times greater than the estimated costs for the first year. This is long after the normal "level-off" period under voluntary insurance experience.

*C. Tendency for continual expansion of administrative force in Government insurance.*—Using the developments in Germany, the country which had the longest experience in compulsory sickness insurance, as an indication of what may be expected in the way of administrative expansion, prior to the last war the number of employees administering the system was almost equal to the number of doctors providing medical services.

The necessity of maintaining detailed records, checking eligibility for benefits, and adjusting claims requires a large administrative force. Furthermore, the lay administrators are charged with protecting the funds of the system. The amount available for medical benefits is limited by contributions which are low in order to be acceptable. In order to keep the benefits equal to or less than the amount available, the administrators must control the amount expended for medical care. This results in pressure on the physicians to act as policemen for the system, and tends to force the physicians to practice in accordance with rules designed to maintain the financial soundness of a system that was originally established on incomplete actuarial data and contributions determined by political expediency.

*D. Cost to the country as a whole.*—The most optimistic estimates seem to be that the medical benefits will cost $3,250,000,000 a year or 4 percent of pay rolls. Experts feel, however, that this is optimistic, that the initial cost will be over $4,000,000,000 and will continue to rise. Medical costs will increase because the public will have a tendency to demand more and more expensive drugs, laboratory analyses, X-rays, and other costly services.

The size of the burden of compulsory sickness insurance must be related to its relation to kindred burdens. To the 4 percent national pay-roll deduction should be added 2 percent for cash benefits, plus 2 percent for old age and survivorship benefits, plus the 1.8 percent average paid for unemployment compensation. Even then competent observers believe that this 9.8 percent of the national pay roll is too small.

*E. Cost to the family.*—In commenting on the costs of compulsory sickness insurance the proponents usually refer to former congressional bills and argue something like this: If you are employed, medical benefits (excluding dental and nursing) for yourself and your family will cost 1.5 percent of your income up to

$3,000—or $3.75 a month. This, of course, is a false generalization. In millions of families today more than one person is working—a wife, a son, a daughter. For these families you must multiply the monthly pay-roll deduction by the number of family members employed.

If you do not wish a "panel" doctor, you would pay both the pay-roll tax and the doctor of your choice.

To the employer: Similar deductions are to be added to the pay rolls as the employers' share, thus reducing possibilities of wage raises and increasing the costs of consumers' goods.

*F. Costs to continue increasing.*—Proponents of compulsory sickness insurance contend that the increase in cost will be offset by better health and more productivity. This sounds reasonable but past experiences indicate that it is probably wishful thinking. The same argument as to the raising of wages and the resultant increase in the workingman's efficiency has proved quite false in recent years. Ask any industrialist what correlation he has found between general wage raises and efficiency.

The desire to get something in return—malingering—the neurotic patient—all will operate to increase costs. In England, the claim rate for wage-loss benefits increased 50 percent in 6 years. In Germany it trebled from 1885 to 1930. From 1914 to 1929 the per capita costs of sickness insurance in Germany increased 300 percent—in England 250 percent.

Estimates of the cost of compulsory sickness insurance and allied programs have reached as high as 10 to 15 billion dollars. No one actually knows what it would be. One suggestion given as to what just $10,000,000,000 adds up to is this: To produce $10,000,000,000 in terms of goods and services, every wage earner and salaried person would have to work 40 hours a week for 5 weeks each year. Except for the poll tax, sales tax, income tax, luxury tax, property tax, and others, the remaining 10 months' and 1 week's pay is yours.

## *X. Expenditures*

*A. Medical-care expenditures in relation to expenditures for nonessential goods and services.*—One of the serious impressions that have been created and made popular under the new social-welfare philosophy is that the majority of the people cannot afford the cost of medical care, and therefore cannot be expected to prepare for such costs. Such a philosophy is very pleasing to many people, since it relieves them of the responsibility of their health and of budgeting for medical-care expense.

It also provides them with a means of justifying their increasing expenditures for such items as recreation and entertainment, alcoholic beverages, tobacco, cosmetics, and jewelry. According to the United States Department of Commerce, the above items, which are ordinarily considered luxuries, or, at least, nonessential goods and services, account for 16.3 percent of the total expenditures for 1942.

Medical care, on the other hand, amounted to 3.4 percent of the total, and of this 1.2 percent was spent for physicians' services, 1.2 percent for drug preparations and sundries, glasses, and orthopedic appliances, while the remainder went to hospitals, nurses, and other related items.

*B. Cost of medical care under present system.*—The average annual cost of good medical care is estimated to be $25 to $30 per person. According to Department of Commerce figures on consumption expenditures in 1942, the average per capita expenditure for medical care was $22.50.

This included medical, hospital, and nursing service, and drugs, glasses, and appliances. In the same year the average per capita expenditure for alcoholic beverages was $38.70, for recreation $34.60, for tobacco $18, and for personal care, including cosmetics, $11.40.

No family can budget its medical care because of the uncertainty of sickness—and whom it strikes—for if it hits the wage earner it is more serious than if it strikes the children.

Likewise, no government can determine its national sick bill and charge any one for it—in advance.

*C. Ratio of expenditures for necessities and nonessential items by money income classes.*—In 1942, about 75 percent of the spending units (families and single consumers) had money income of $3,000 or less. The consumer expenditures reflect the expenditures then of this $3,000 or under income group. A further break-down of expenditures by money income classes, obtained from figures published in the Statistical Abstract of the United States, 1944–45, shows that the percentage of income used for medical care by any of the income classes, $3,000 and under, is approximately the same as the percentage used by the $3,000 to $5,000 income class. Expenditures for recreation, entertainment, tobacco, etc., are about the same in percentage to income for the various income classes under $5,000. Expenditures for necessities and nonessential goods and services as measured by ratio to total income do not vary greatly by income classes, except in regard to saving.

Low income families do not spend a greater percentage of their income for medical care, nor do they spend less in percentage of income for nonessential goods and services. A tax on income to support a compulsory sickness insurance system will not change the ratio of expenditures. The low income families will be paying their share of the cost of medical care, and of supporting a large administrative organization as well.

### *XI. The present system has given great progress*

*A. In the reduction of death rates.*—The statement that we are not the healthiets Nation in the world has been made based on mortality rates in various countries. A comparison of these statistics alone provides no explanation for the many differences between countries.

The latest mortality figures for other countries are usually quoted as of 1942. They are for general death rates and infant death rates only.

We know very little as to methods other countries use in compiling statistics—or of the special characteristics of the countries. We do know, however, that the United States is the only country that includes all races in its statistics.

The only countries that compare with the United States are New Zealand, Union of South Africa, Sweden, Canada, and Australia and they are all about on a par. Only one has compulsory sickness insurance—New Zealand. None of these are actually comparable to the United States in population, diversity of races, etc.

*B. Greatest progress in reduction of death rate in the United States.*—Vital statistics prior to the war provided figures on rates from specific causes for the various countries. These figures showed that the United States, New Zealand, Sweden, and Australia were making the greatest progress in improving health as measured by the mortality rates. At that time none of these countries had compulsory sickness insurance systems. It is apparent that living conditions and the characteristics of the people are the important factors for improved health, and that compulsory sickness insurance may retard but will not increase the progress in that respect.

*C. In life expectancy.*—An article by Louis I. Dublin and Alfred J. Lotka, which appeared in the January 1945 issue of the Annals of the American Academy of Political and Social Science, contained the latest comparative figures on expectation of life in various countries.

| | Period | At birth | | At birth | |
|---|---|---|---|---|---|
| | | Male | Female | Male | Female |
| 1. New Zealand | 1934–38 | 65.4 | 68.4 | 32.0 | 34.0 |
| 2. Australia | 1932–34 | 63.4 | 67.1 | 31.1 | 32.0 |
| 3. Sweden | 1931–35 | 63.2 | 65.3 | 32.5 | 33.5 |
| 4. United States | 1930–39 | 60.6 | 64.5 | 29.6 | 32.2 |
| 5. England and Wales | 1937 | 60.1 | 64.4 | 29.5 | 32.7 |
| 6. Germany | 1932–34 | 59.8 | 62.8 | 30.8 | 32.3 |
| 7. France | 1928–33 | 54.3 | 59.0 | 27.6 | 31.3 |
| 8. Italy | 1930–32 | 53.7 | 56.0 | 30.3 | 32.4 |

The four leading countries did not have compulsory sickness insurance.

In 1942 the life expectancy at birth for the United States was: Male, 64; female, 69, an increase of about 15 years between 1902 and 1942.

*D. United States has high general death rate due to auto accidents.*—Another factor that is important in the differences is the high death rate in the United States from automobile accidents. Although we do not have recent figures for other countries, in 1938 the rate in the United States was twice as high as the rate in Canada and England. If adjustments were made for just these two factors—differences in race and auto accidents—the general death rates would be more comparable, and the rate for United States would be lower than other countries.

*E. Accident death rate.*—For all ages, accidents are the fifth leading cause of death. For only nephritis, cerebral hemorrhages, cancer and heart diseases do we have a higher mortality rate, and all of these are diseases of old age.

In the age group, 1 to 19 years, accidents are the leading cause of death. In discussing the health of the Nation and the need for Government sickness insurance, these facts are avoided. The unnecessary deaths caused by accidents will not be reduced by a Government insurance program, but its proponents lead the people to believe that it is an imaginary economic barrier to obtaining medical care that is responsible for the high death rate and large number of young people with physical impairments.

*F. Infant mortality on comparative basis as low in the United States as in other countries.*—The figures on infant mortality show that this country ranked fifth among all countries in 1942. New Zealand has consistently had a low infant death rate, and in recent years has shown very little change. Sweden had the next lowest rate. Both Sweden and New Zealand are small countries with homogeneous population enjoying a high standard of living. Many States, such as Minnesota, Washington, Oregon, Connecticut, New Jersey, New York or Wisconsin, which are more comparable as to conditions, population and size to Sweden and New Zealand, have approximately as low infant death rates.

### *XII. Voluntary sickness insurance*

*A.*—Voluntary arrangements for insurance against the costs of medical care have been available through various forms of accident and health policies. The premiums for such policies varied with the benefits provided. When sold on an individual basis, the premiums usually were too high for the majority of the people. In the last 15 years group enrollment through place of employment enabled the insurance companies to offer accident and health insurance at much more favorable rates. Recent reports indicate that over 40,000,000 persons are covered by some form of accident and health insurance.

Such insurance policies provide cash reimbursement to the insured for expenses due to medical care or loss of wages during illness. Under such arrangements there are no restrictions or interference by the insurance company on the amount or type of medical care obtained by the insured. The policies state the conditions under which benefits will be paid and the maximum amount.

Greater use of hospttals for the diagnosis and treatment of illness and increased cost of medical care due to advancement in medical science requiring the use of expensive equipment and drugs in hospitals made hospital costs a major factor in the cost of medical care.

During the depression years of the 1930's, hospital and welfare administrators, as well as physicians, became interested in nonprofit plans to spread the cost of hospital care through regular prepayment arrangements. These nonprofit prepayment hospital service plans became known as the Blue Cross hospital service plans because the commission on hospital service of the American Hospital Association adopted the Blue Cross as a symbol of approval. In 1946, there were 87 Blue Cross plans with over 21,000,000 subscribers.

A somewhat later development of voluntary prepayment medical care plans, sponsored by State and county medical societies, provide a similar arrangement for spreading the cost of medical care. In the early part of 1946, such plans were operating in 31 States, and considerable progress was being made in establishing plans in other States. Enrollment in these plans was growing rapidly, although the number was not large (about 3,500,000) when compared with the Blue Cross hospital service plans. Increased education of the public on the advantages of prepayment arrangements for medical care, and on the cost of good medical care, plus greater coordination of existing plans and simplified enrollment procedures, should enable every industrious individual and family to obtain adequate protection against the major costs for medical and hospital care.

*B. Plan development.*—Physicians are very highly trained persons, and medicine is practiced under more exacting standards than any other profession. Advancements in the science of medicine have been rapid and continuous. It is, therefore, necessary for a physician to devote considerable time to the study of medicine even after he has graduated from a rigorous course of formal education and training.

People in other professions or activities frequently claim that although the physicians are well qualified for their professional duties, they are not doing a good job in distributing their services, and that the cost of good medical care is too high. These people usually have a desire to take part in a program in which the physicians' services will be retailed through a governmental social welfare agency. Actually individual physicians and medical societies have spent a great deal of effort and money over the years investigating and testing means of improving the distribution of medical care and of reducing the cost.

These voluntary prepayment plans for medical and hospital care are the result of years of study and experimentation. The basic principles have been developed to protect the public, maintain and encourage the advancement of medical science, and allow the physicians freedom to practice according to the highest professional standards. Voluntary arrangements require that individuals be responsible for their own health, whereas compulsory arrangements penalize such responsibility. Medical care is not expensive compared with other goods and services, and the amount paid by individuals or families is small in comparison to the amount spent by the same individuals for entertainment, alcoholic beverages, cosmetics, and tobacco.

*C. Plans in keeping with American way of life.*—The trend in recent years is toward greater Government responsibility for the individual welfare. The main theme of many social scientists, union officials, and social-security officials is that the people must be provided through no effort of their own with various necessities of life, but primarily medical and hospital care. The amount of money spent by these groups to educate the people along this line of thinking is not known, but it amounts to a great deal.

If as much effort and money were expended for educating the people on how to maintain their health by making use of the advantages of improved diet and sanitation and regular and early treatment by physicians when medical care is needed, much more would be accomplished. People have also been highly educated through costly advertising to buy patented drugs for self-treatment, and they are easily misled by various cults that promise cures for everything. The consumer expenditure for patented drugs and the services of cultist and secondary healing practitioners are about equal to the amount paid to physicians. Still the emphasis of the social-welfare philosophers is on cheaper or free service of physicians. Physicians are aware of this situation, but they are accused of interest only in financial gain if they attempt to show that for the country as a whole, a larger expenditure for good medical care is less costly in the long run.

People can be educated to greater consciousness of individual responsibility for their welfare, but it is not as easy as leading them into increased Government responsibility particularly when the governmental agencies make use of tax funds and deficit financing to increase the desire of the people for more governmental services. Voluntary insurance and prepayment arrangements for medical care are an important factor in encouraging individual responsibility.

(Whereupon, at 12:05 p. m., the subcommittee adjourned until 10 o'clock a. m. Wednesday, June 25, 1947.)

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